

Choice Plus plan details, all in one place

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Coverage Period 01/01/2026 - 12/31/2026

Check out what's included in the plan	Choice Plus
 Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
 Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities – but staying in the network can help lower your costs.	☒
 Primary care physician (PCP) required With this plan, you need to select a PCP – the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
 Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
 Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☒
 Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☐
 Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☐
 Freestanding centers You may pay less when you use certain freestanding centers – health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
 Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☐

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

Here's a more in-depth look at how Choice Plus works

Medical Benefits

Effective Date: January 1, 2026

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	You do not have to pay a medical deductible.	\$250
Family	You do not have to pay a medical deductible.	\$500

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	\$5,600	\$4,000
Family	\$11,200	\$8,000

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.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Preventive Care Services		
Preventive Care Services	No copay	20%*
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 copay, co-insurance or deductible.		
Childhood immunizations are not subject to payment of the Annual deductible.		
Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography (including 3D Mammograms) and Colorectal Cancer Screenings.		

*After the Annual Medical Deductible has been met.

†Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Office Services - Sickness & Injury		
Primary Care Physician	\$10 copay	20%*
<i>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</i> <i>No cost for in-network allergy injections when no other service is provided during the office visit.</i> <i>Telehealth is covered at the same cost share as in the office.</i>		
Specialist	\$10 copay	20%*
<i>Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.</i> <i>No cost for in-network allergy injections when no other service is provided during the office visit.</i> <i>Telehealth is covered at the same cost share as in the office.</i>		
Urgent Care Center Services	\$10 copay	20%*
Virtual Care Services	No copay	Not covered
<i>Network Benefits are available only when services are delivered through a Designated Virtual Network Provider for 24/7 Virtual Visit services only. You can find a 24/7 Virtual Visit Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to 24/7 Virtual Visits and prescription services may not be available in all states or for all groups.</i>		
Emergency Care		
Ambulance Services - Emergency Ambulance		
Air Ambulance	No copay	No copay
Ground Ambulance	No copay	No copay
Ambulance Services - Non-Emergency Ambulance¹		
Air Ambulance	No copay	No copay
Ground Ambulance	No copay	20%*
Dental Services - Accident Only	No copay	No copay

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Network	Out-of-Network
\$35 copay	\$35 copay
No copay	20%*
The amount you pay is based on where the covered health care service is provided.	
No copay	20%*
No copay	20%*
\$10 copay	20%*
No copay	20%*
No copay	Not covered
No copay	20%*
No copay	20%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
Physician Fees for Surgical and Medical Services	No copay	20%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	\$10 copay	20%*
<i>Limited to 100 visits of cardiac rehabilitation therapy per year.</i>		
<i>Limited to 20 visits of cognitive rehabilitation therapy per year.</i>		
<i>Limited to 20 visits of occupational therapy per year.</i>		
<i>Limited to 20 visits of pulmonary rehabilitation therapy per year.</i>		
<i>Limited to 20 visits of speech therapy per year.</i>		
<i>Limited to 30 visits of manipulative treatments per year.</i>		
<i>Limited to 30 visits of post-cochlear implant aural therapy per year.</i>		
<i>Limited to 60 visits of physical therapy per year.</i>		
<i>There are no limits if prescribed for treatment of a mental health condition or substance-related and addictive disorder.</i>		
Scopic Procedures - Outpatient Diagnostic and Therapeutic	No copay	20%*
<i>Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.</i>		
<i>For network benefits you have no copay for a diagnostic colonoscopy for the first service in a year.</i>		
Surgery - Outpatient ¹	No copay	20%*
Therapeutic Treatments - Outpatient ¹	No copay	20%*
<i>Out-of-Network Benefits are not covered for dialysis services.</i>		
<i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.</i>		
Supplies and Services		
Diabetes Self-Management Items ¹	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care ¹	The amount you pay is based on where the covered health care service is provided.	
Durable Medical Equipment (DME), Orthotics and Supplies	No copay	Not covered
<i>Limited to a single purchase of a type of DME or orthotic every 3 years.</i>		
<i>Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.</i>		
Enteral Nutrition	No copay	20%*
Hearing Aids	No copay	No copay
<i>Limited to \$3,000 per year.</i>		
<i>Limited to a single purchase per hearing impaired ear every 3 years.</i>		
<i>Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.</i>		
Ostomy Supplies	No copay	Not covered
Pharmaceutical Products - Outpatient	No copay	20%*
<i>This includes medications given at a doctor's office, or in a covered person's home.</i>		
Prosthetic Devices ¹	No copay	20%*
<i>Limited to a single purchase of each type of prosthetic device every 3 years.</i>		
<i>Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.</i>		
Urinary Catheters	No copay	Not covered
Pregnancy		
Pregnancy - Maternity Services ¹	The amount you pay is based on where the covered health care service is provided except that all payments will not apply for a newborn child up to 31 days after birth and will be assumed under the insured.	
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient ¹	No copay	20%*
Intensive Behavioral Therapy (e.g. ABA) ¹	No copay	20%*

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Other Outpatient Services such as Electro-Convulsive Treatment, Psychological Testing, Transcranial Magnetic Stimulation and Medication Assisted Treatment¹	No copay	20%*
Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Programs¹	No copay	20%*
Outpatient Office Visits	No copay	20%*
Other Services		
Cellular and Gene Therapy	The amount you pay is based on where the covered health care service is provided.	Not covered
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.		
Clinical Trials¹	The amount you pay is based on where the covered health care service is provided.	
Dental Anesthesia¹	The amount you pay is based on where the covered health care service is provided.	
Fertility Preservation for Iatrogenic Infertility¹	No copay	20%*
Limited to \$20,000 per Covered Person per lifetime.		
Limited to \$5,000 for Prescription Drug Products per Covered Person.		
Limited to 1 cycle of fertility preservation for Iatrogenic Infertility per lifetime.		
This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services.		
Gender Dysphoria¹	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Limits for voice modification therapy and/or voice lessons will be the same as, and combined with, outpatient speech therapy limits as described under Habilitative Services and Rehabilitation Services Outpatient Therapy and Manipulative Treatment.		
Hospice Care¹	No copay	20%*
Medical Foods	No copay	50%

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
Oral Surgery	No copay	20%*
<i>Benefits are not available for an Inpatient Stay in a Hospital or for simple extractions where no cutting is involved.</i>		
Preimplantation Genetic Testing (PGT) and Related Services ¹	No copay	20%*
<i>Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.</i>		
Reconstructive Procedures ¹	The amount you pay is based on where the covered health care service is provided.	
Transplantation Services	The amount you pay is based on where the covered health care service is provided.	Not covered
<i>For Network Benefits, transplantation services must be received from a Designated Provider.</i>		

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

Here's an example of how the plan's costs come into play

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you – this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year – copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, \$15) –or **copay** – for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

*Your coinsurance may vary by service. This example is for illustrative purposes only.

Digital tools to keep you connected

Once you're a member, you can access your personalized digital tools – the **UnitedHealthcare® app** and **myuhc.com®** – these tools give you quick access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Quickly compare cost estimates before you get care, which may help you save money

Get connected

Scan this code to download the UnitedHealthcare app or visit myuhc.com



Other important information about your benefits

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders 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.

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult/Child)
- Routine Foot Care
- Weight Loss Programs

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator

UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at:

<http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어 (**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

توضيح: خدمات الترجمة متاحة للأشخاص الذين يتحدثون اللغة العربية (**Arabic**)، دون مقابل. يرجى الاتصال بالرقم المجاني المذكور على بطاقة هويتك. نأمل أن تكون بخير.

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (**Italian**), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते हैं, आपको भाषा सहायता सेवाएं, नशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (**Hmong**), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά (**Greek**), υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

PAKDAAR: Nu saritaem ti Ilocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍI BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yánílti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shq'odí ninaaltsoos nítł'izi bee nééhozinígíí bine'déé' t'áá jíík'ehgo béesh bee hane'í biká'ígíí bee hodiilnih.

OGOW: Haddii aad ku hadasho Soomaali (**Somali**), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વગરના મૂલ્યે પ્રાપ્ય છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિ પર આપેલા સભ્ય માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.