UnitedHealthcare®

# Benefit Summary

New Jersey - Choice
Balanced 100 - Plan BOS6

## 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 care services, when possible.

## What are the benefits of the Choice Plan?

**Use our national network to save money.**

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in our network.

> **Save money by staying in our network.** If you don't use the network, you'll have to pay for all of the costs.

> **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.**

**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.

**Not enrolled yet?** Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choice** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

## 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) |
|---|---|---|
| $40 | $2,500 | You have no co-insurance. |

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), Schedule of Benefits, 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

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

**Your cost if you use Network Benefits**

### Annual Deductible

**What is an annual deductible?**

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service.

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

| | |
|---|---|
| Medical Deductible - Individual | $2,500 per year |
| Medical Deductible - Family | $5,000 per year |

### Out-of-Pocket Limit

**What is an out-of-pocket limit?**

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

| | |
|---|---|
| Out-of-Pocket Limit - Individual | $3,500 per year |
| Out-of-Pocket Limit - Family | $7,000 per year |

## Your Costs

**What is co-insurance?**

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). 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 is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $50). You are responsible for paying the lesser of the applicable Co-payment or 50% of the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

**What is Prior Authorization?**

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization.

**Want more information?**

Find additional definitions in the glossary at justplainclear.com.

## Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Ambulance Services** | |
| Emergency Ambulance: | You pay nothing, after the medical deductible has been met. |
| Non-Emergency Ambulance: | You pay nothing, after the medical deductible has been met.<br>Prior Authorization is required for Non-Emergency Ambulance. |
| **Autism Spectrum Disorder and Other Developmental Disabilities - Rehabilitative Services** | |
| Inpatient:<br>Limited to 60 days per year.<br><br>Limits do not apply to the treatment of Autism Spectrum Disorder. | You pay nothing, after the medical deductible has been met. |
| Outpatient:<br>20 visits of physical therapy.<br>20 visits of occupational therapy.<br>20 visits of speech therapy.<br><br>Limits do not apply to the treatment of Autism Spectrum Disorder. | $40 co-pay per visit. A deductible does not apply. |
| **Cellular and Gene Therapy** | |
| Cellular or Gene Therapy services must be received from a Designated Provider. | The amount you pay is based on where the covered health care service is provided.<br>Prior Authorization is required. |
| **Clinical Trials** | |
| | The amount you pay is based on where the covered health care service is provided.<br>Prior Authorization is required. |
| **Congenital Heart Disease (CHD) Surgeries** | |
| | You pay nothing, after the medical deductible has been met. |
| **Dental Services - Accident Only** | |
| | You pay nothing, after the medical deductible has been met. |
| **Dental Services - Other** | |
| | The amount you pay is based on where the covered health care service is provided.<br>Prior Authorization is required. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Diabetes Services** | |
| Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care: | The amount you pay is based on where the covered health care service is provided. |
| Diabetes Self-Management Items: | The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME) and Supplies and in the Outpatient Prescription Drug Rider. |
| **Durable Medical Equipment (DME) and Supplies** | |
| Limited to a single purchase of a type of DME every three years. Repair and/or replacement of DME would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums. | You pay nothing, after the medical deductible has been met. |
| **Early Intervention Family Cost Share Expense** | |
| The Annual Deductible, co-insurance or co-payment as applicable to a non-Specialist Physician visit for treatment of a Sickness or Injury will apply to the monthly Family Cost Share expense. | $40 co-pay per visit. A deductible does not apply. |
| **Emergency Health Care Services - Outpatient** | |
| | $100 co-pay per visit. A deductible does not apply.<br>Notification is required if confined in an Out-of-Network Hospital. |
| **Gender Dysphoria** | |
| | The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider.<br>Prior Authorization is required for certain services. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Habilitative Services** | |
| Inpatient:<br>Inpatient services limited per year as follows:<br>Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services. | The amount you pay is based on where the covered health care service is provided. |
| Outpatient:<br>Outpatient therapies:<br>Physical therapy.<br>Occupational therapy.<br>Manipulative Treatment.<br>Speech therapy.<br>Post-cochlear implant aural therapy.<br>Cognitive therapy.<br>For the above outpatient therapies:<br>Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment. | $30 co-pay per visit for manipulative treatment. A deductible does not apply.<br>$30 co-pay per visit for all other habilitative services. A deductible does not apply. |
| **Hearing Aids** | |
| Limited to one hearing aid per hearing impaired ear every 24 months for Covered Persons under age 16. | $40 co-pay per hearing aid. A deductible does not apply. |
| Limited to $2,500 per hearing impaired ear every 24 months for Covered Persons age 16 and over. Accessories, fittings and repairs are not subject to the $2,500 limit. | |
| **Hearing Loss Screening** | |
| | You pay nothing. A deductible does not apply. |
| **Hemophilia Services** | |
| | You pay nothing, after the medical deductible has been met. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Home Health Care** | |
| Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.<br>For the administration of intravenous infusion, you must receive services from a provider we identify. | You pay nothing, after the medical deductible has been met. |
| **Hospice Care** | |
| | You pay nothing, after the medical deductible has been met. |
| **Hospital - Inpatient Stay** | |
| | You pay nothing, after the medical deductible has been met. |
| **Infertility Services** | |
| Limited to four completed egg retrievals (and the procedures and treatments associated with such retrievals) while covered under this plan or any plan with the same employer. | You pay nothing, after the medical deductible has been met.<br><br>Prior Authorization is required. |
| **Lab, X-Ray and Diagnostic - Outpatient** | |
| Lab Testing - Outpatient:<br>Limited to 18 Presumptive Drug Tests per year.<br>Limited to 18 Definitive Drug Tests per year. | You pay nothing, after the medical deductible has been met. |
| X-Ray and Other Diagnostic Testing - Outpatient: | You pay nothing, after the medical deductible has been met. |
| **Major Diagnostic and Imaging - Outpatient** | |
| | You pay nothing, after the medical deductible has been met. |
| **Medical Foods** | |
| | You pay nothing, after the medical deductible has been met. |

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Mental Health Care and Substance Use Disorders Services** | |
| Inpatient: | You pay nothing, after the medical deductible has been met. |
| Outpatient: | $30 co-pay per visit. A deductible does not apply. |
| Partial Hospitalization/Intensive Outpatient Treatment: | You pay nothing, after the medical deductible has been met. |
| **Ostomy Supplies** | |
| | You pay nothing, 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. | You pay nothing, after the medical deductible has been met. |
| **Physician Fees for Surgical and Medical Services** | |
| | You pay nothing, after the medical deductible has been met. |
| **Physician's Office Services - Sickness and Injury** | |
| | $40 co-pay per visit for a primary care physician office visit. A deductible does not apply.<br>$60 co-pay per visit for a specialist office visit. A deductible does not apply. |

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

| | |
|---|---|
| **Pregnancy - Maternity Services** | |
| | The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. |
| **Prescription Drug Benefits** | |
| Prescription drug benefits are shown in the Prescription Drug benefit summary. | |
| **Preventive Care Services** | |
| Physician Office Services, Lab, X-Ray or other preventive tests. | You pay nothing. A 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.

## Your Costs

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Prosthetic Devices and Orthotics** | |
| Please Note: Reimbursement for these items will be at the same rate as under the federal Medicare reimbursement schedule. | $40 co-pay. A deductible does not apply. |
| **Reconstructive Procedures** | |
| | The amount you pay is based on where the covered health care service is provided. |
| **Rehabilitation Services - Outpatient Therapy and Manipulative Treatment** | |
| Limited to:<br>20 visits of pulmonary rehabilitation therapy.<br>36 visits of cardiac rehabilitation therapy.<br>20 visits of physical therapy.<br>20 visits of occupational therapy.<br>20 visits of speech therapy.<br>30 visits of post-cochlear implant aural therapy.<br>20 visits of cognitive rehabilitation therapy.<br>20 visits of Manipulative Treatments. | $30 co-pay per visit for manipulative treatment. A deductible does not apply.<br><br>$30 co-pay per visit for all other rehabilitation services. A deductible does not apply. |
| **Scopic Procedures - Outpatient Diagnostic and Therapeutic** | |
| Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy. | You pay nothing, after the medical deductible has been met. |
| **Skilled Nursing Facility / Inpatient Rehabilitation Facility Services** | |
| Limited to 60 days per year. | You pay nothing, after the medical deductible has been met. |
| **Specialized Non-Standard Infant Formulas** | |
| | You pay nothing, after the medical deductible has been met. |
| **Surgery - Outpatient** | |
| | You pay nothing, after the medical deductible has been met. |

| Covered Health Care Services | Your cost if you use Network Benefits |
|---|---|
| **Therapeutic Treatments - Outpatient** | |
| Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology. | You pay nothing, after the medical deductible has been met. |
| **Transplantation Services** | |
| Network Benefits must be received from a Designated Provider. | The amount you pay is based on where the covered health care service is provided.<br>Prior Authorization is required. |
| **Urgent Care Center Services** | |
| | $75 co-pay per visit. A deductible does not apply. |
| Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work. | |
| **Virtual Visits** | |
| Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or 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.<br><br>We also provide benefits for Virtual Visits. We contract with one or more entities to create a Designated Virtual Network. Each of these entities creating the Virtual network contracts with individual providers or groups of providers. We refer to a provider in the Designated Virtual Network as a Designated Virtual Network Provider. | $10 co-pay per visit. A deductible does not apply. |

**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
- 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

**For Internal Use only:**

**NJMAA03BOS619**

| **Item#** | **Rev. Date** | |
|---|---|---|
| 480-6555 | 0419 | Base/Value/Sep/Emb/44187/2018 |

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

**Online:** UHC_Civil_Rights@uhc.com

**Mail:** Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 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, 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. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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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 **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

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. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क 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.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh 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.