# Summary of Benefits

## *UnitedHealthcare Choice Plan*

ARCHDIOCESE of NEW YORK

# Archdiocese of New York

***Active Plan for Non-Bargaining Lay and Religious***

***Effective January 1, 2019, if you have any questions please call United HealthCare (UHC) Member Services at 1-800-736-1264 or register at myuhc.com to get detailed information on your coverage***

Choice plan gives you the freedom to see any Physician or other health care professional from the UHC Network, including specialists, without a referral. ***This plan does not cover out of network benefits.*** 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.

## *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.
- United Healthcare's NurseLine connects you to registered nurses and a library of recorded programs on important health topics 24 hours a day, 7 days a week, from anywhere in U.S.
- We offer the Language Line Services so that you can talk with us in 140 different languages. Just call customer service and ask for an interpreter.
- Emergencies are covered anywhere in the world, in- or out-of-network.
- Care Coordination℠ services are available to help identify and prevent delays in care for those who might need specialized help.
- The tools and information at myuhc.com are practical and personalized so you can get the most out of your benefits. Register at myuhc.com and connect to current information about your benefits and health care interests.
- Cancer Resource Services provides information on comprehensive cancer treatment services.
- Benefit from using one of our **Centers of Excellence** by calling NurseLine where the nurses can lead you to the correct facility for your condition.

# YOUR BENEFITS

| Type of Coverage | Premium Providers | UHC Network | Out of Network |
|---|---|---|---|
| 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.<br>**More complete descriptions of Benefits and the terms under which they are provided are contained in the Summary Plan Description.**<br>If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail.<br>Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.<br>Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.<br>*Prior Notification is required for certain services. | **Annual Deductible:** $200 per Covered Person per calendar year, not to exceed $400 for all Covered Persons in a family.<br>**Out-of-Pocket Maximum:** $1,500 per Covered Person per calendar year, not to exceed $3,000 per family. The Out-of-Pocket Maximum does include the Annual Deductible and Copayments for covered health services.<br>**Maximum Plan Benefit:** No Maximum Plan Benefit.<br>**Member Pays** | **Annual Deductible:** $300 per Covered Person per calendar year, not to exceed $600 for all Covered Persons in a family.<br>**Out-of-Pocket Maximum:** $2,000 per Covered Person per calendar year, not to exceed $4,000 per family. The Out-of-Pocket Maximum does include the Annual Deductible and Copayments for covered health expenses.<br>**Maximum Plan Benefit:** No Maximum Plan Benefit.<br>**Member Pays** | **NO COVERAGE** |
| **Annual Routine Physical Exam** | $0<br>Preventive Medical care includes:<br>Well Adult, Child & Baby exams<br>Immunizations, Voluntary Family Planning<br>Vision & Hearing Screenings | $0<br>Preventive Medical care includes:<br>Well Adult, Child & Baby exams<br>Immunizations, Voluntary Family Planning<br>Vision & Hearing Screenings | **NO COVERAGE** |
| **Laboratory Tests:** | $0<br>Preventive Lab Tests, Mammograms,<br>Pap smears, diagnostic consults to prevent<br>Disease and detect abnormalities, tests to support Cardiovascular health | $0<br>Preventive Lab Tests, Mammograms,<br>Pap smears, diagnostic consults to prevent<br>Disease and detect abnormalities, tests to support Cardiovascular health | **NO COVERAGE** |
| **Physician's Office Services**<br>Copay does not apply to preventive services | $25 | $40 | **NO COVERAGE** |
| **Ambulance Service – Emergency Only** | Ground Transportation: 25% of Eligible Expenses after satisfying deductible<br>Air Transportation: 25% of Eligible Expenses after satisfying deductible | Ground Transportation: 25% of Eligible Expenses after satisfying deductible<br>Air Transportation: 25% of Eligible Expenses after satisfying deductible | True Emergency – Same as network benefit.<br>Non-emergency - **NO COVERAGE** |
| **Dental Services - Accident only** (must begin within 6 months of injury | 25% of Eligible Expenses after satisfying deductible | 25% of Eligible Expenses after satisfying deductible | **NO COVERAGE** |
| **Durable Medical Equipment** (the purchase or rental of prescribed equipment is covered, including needed replacement and repairs) | 25% of Eligible Expenses after satisfying deductible | 25% of Eligible Expenses after satisfying deductible | **NO COVERAGE** |
| **Emergency Health Services** | $150 per visit (copay waived if admitted) | $150 per visit (copay waived if admitted) | True Emergency – Same as network benefit.<br>Non-emergency – **NO COVERAGE** |
| **Refractive Eye Examinations** | No Coverage | No Coverage | **NO COVERAGE** |
| **Home Health Care**<br>Network Benefits are limited to 200 visits per calendar year | 25% of Eligible Expenses after satisfying deductible | 25% of Eligible Expenses after satisfying deductible | **NO COVERAGE** |
| **Hospice Care**<br>No annual maximum | 25% of Eligible Expenses after satisfying deductible | 25% of Eligible Expenses after satisfying deductible | **NO COVERAGE** |

# YOUR BENEFITS

| Type of Coverage | Premium Providers | UHC Network | Out of Network |
|---|---|---|---|
| **Virtual Visits**<br>Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at 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. | No Coverage | $15 Per Visit | **NO COVERAGE** |
| **Hospital – Inpatient Stay** | 25% of Eligible Expenses after satisfying deductible | 25% of Eligible Expenses after satisfying deductible | **NO COVERAGE** |
| **Injections Received in a Physician's Office** | $25 per visit | $35 per visit | **NO COVERAGE** |
| **Maternity Services** | Delivery - 25% of Eligible Expenses after satisfying deductible.<br>Prenatal visit – 100% after $25 copay (copay applies to first prenatal visit only.<br>Outpatient Diagnostic Services - 25% of Eligible Expenses after satisfying deductible.<br>Mother's Hospital Charge - 25% of Eligible Expenses after satisfying deductible.<br>Newborn Nursery Charge - 25% of Eligible Expenses waive deductible. | Delivery - 25% of Eligible Expenses after satisfying deductible.<br>Prenatal visit – 100% after $35 copay (copay applies to first prenatal visit only.<br>Outpatient Diagnostic Services - 25% of Eligible Expenses after satisfying deductible.<br>Mother's Hospital Charge - 25% of Eligible Expenses after satisfying deductible.<br>Newborn Nursery Charge - 25% of Eligible Expenses waive deductible. | **NO COVERAGE** |
| **Outpatient Surgery, Diagnostic and Therapeutic Services.**<br>Outpatient Surgery<br>Outpatient Diagnostic Services. | 25% of Eligible Expenses after satisfying deductible.<br>For lab and radiology/X-ray: 25% of Eligible Expenses after satisfying deductible.<br>For mammography testing: 25% of Eligible Expenses after satisfying deductible.<br>Preventive service covered at 100%. | 25% of Eligible Expenses after satisfying deductible.<br>For lab and radiology/X-ray: 25% of Eligible Expenses after satisfying deductible.<br>For mammography testing: 25% of Eligible Expenses after satisfying deductible.<br>Preventive service covered at 100%. | **NO COVERAGE** |
| Outpatient Diagnostic/Therapeutic Services:<br>Scans, Pet Scans, MRI and Nuclear Medicine | 25% of Eligible Expenses after satisfying deductible. | 25% of Eligible Expenses after satisfying deductible. | |
| Outpatient Therapeutic Treatments | 25% of Eligible Expenses after satisfying deductible. | | |
| **Professional Fees for Surgical and Medical Services** | 20% of Eligible Expenses after satisfying deductible | 25% of Eligible Expenses after satisfying deductible | **NO COVERAGE** |
| **Prosthetic Devices**<br>(The purchase or rental of prescribed equipment is covered, including needed replacement and repairs) | 25% of Eligible Expenses after satisfying deductible | 25% of Eligible Expenses after satisfying deductible | **NO COVERAGE** |
| **Reconstructive Procedures** | Hospital Inpatient Stay – 25% of Eligible Expenses after satisfying deductible.<br>Outpatient Surgery - 25% of Eligible Expenses after satisfying deductible.<br>Outpatient Diagnostic Therapeutic Services – 25% of Eligible Expenses after satisfying deductible.<br>Outpatient Therapeutic Treatments - 25% of Eligible Expenses after satisfying deductible.<br>Physician's Office Services - $25 per visit. | Hospital Inpatient Stay – 25% of Eligible Expenses after satisfying deductible.<br>Outpatient Surgery - 25% of Eligible Expenses after satisfying deductible.<br>Outpatient Diagnostic Therapeutic Services – 25% of Eligible Expenses after satisfying deductible.<br>Outpatient Therapeutic Treatments - 25% of Eligible Expenses after satisfying deductible.<br>Physician's Office Services - $35 per visit. | **NO COVERAGE** |

*Prior Notification is required for certain services.

| Type of Coverage | Premium Providers | UHC Network | Out of Network |
|---|---|---|---|
| **Rehabilitation Services -Outpatient Therapy** Network and Non-Network Benefits are limited as follows: 90 visits per year for all types of therapy combined (physical therapy, occupational therapy, cardiac rehabilitation, and restorative speech therapy. | $35 per visit | $35 per visit | **NO COVERAGE** |
| **Skilled Nursing Facility/Inpatient Rehabilitation Facility Services** Network Benefits are limited to 120 days per calendar year. | 25% of Eligible Expenses after satisfying deductible | 25% of Eligible Expenses after satisfying deductible | **NO COVERAGE** |
| **Transplantation Services** | *Services rendered via United Resource Network - $0 copay for all professional and facility related expenses. Includes travel and lodging benefit up to maximum of $10,000.<br><br>Services rendered at UHC Hospital which is not part of the United Resource Network – 25% of Eligible Expenses after satisfying deductible. | *Services rendered via United Resource Network - $0 copay for all professional and facility related expenses. Includes travel and lodging benefit up to maximum of $10,000.<br><br>Services rendered at UHC Hospital which is not part of the United Resource Network – 25% of Eligible Expenses after satisfying deductible. | **NO COVERAGE** |
| **Urgent Care Center Services** | $35 per visit | $35 per visit | True Emergency – Same as network benefit.<br><br>Non-emergency – **NO COVERAGE** |
| **Mental Health Services – Outpatient**<br><br>**Substance Abuse Services - Outpatient** | $35 per visit.<br><br>$35 per visit. | $35 per visit.<br><br>$35 per visit. | **NO COVERAGE** |
| **Mental Health Services – Inpatient and Intermediate**<br><br>**Substance abuse Services – Inpatient and Intermediate** | 25% of Eligible Expenses after satisfying deductible<br><br>25% of Eligible Expenses after satisfying deductible | 25% of Eligible Expenses after satisfying deductible<br><br>25% of Eligible Expenses after satisfying deductible | **NO COVERAGE** |
| **Spinal Treatment** (Limited to 60 visits per calendar year in network). | $35 per visit | $35 per visit | **NO COVERAGE** |
| **Prescription Drugs –** Rx vendor is CVS/Caremark (1-800-565-7091).<br>Pharmacy fills: On the third fill of a maintenance drug at the retail pharmacy, the copay changes to $20/50/100 per 30 day supply.<br>Generic Incentive: When you fill a Rx for a brand name drug that has a generic equivalent you pay the brand name copay plus the difference in the cost between the brand name and its generic equivalent.<br>Generic Step Therapy: In select therapeutic classes, you are required to try a cost-effective generic alternative before a brand is covered.<br>Maintenance Choice: Plan enhancement that allows you to fill a 90-day supply of maintenance drugs at a retail pharmacy for the mail order co-pay. | Retail Drug Program<br>$10 per 30-day supply for generic drugs.<br>$25 per 30-day supply for preferred drugs.<br>$50 per 30-day supply for non-preferred drugs.<br><br>Mail Order Program<br>$20 per 90-day supply for generic drugs<br>$50 per 90-day supply for preferred drugs<br>$100 per 90-day supply for non-preferred drugs<br><br>Rx Out-Of-Pocket Maximum<br>$3,000 per covered person per calendar year not to exceed $6,000 per family | Retail Drug Program<br>$10 per 30-day supply for generic drugs.<br>$25 per 30-day supply for preferred drugs.<br>$50 per 30-day supply for non-preferred drugs.<br><br>Mail Order Program<br>$20 per 90-day supply for generic drugs<br>$50 per 90-day supply for preferred drugs<br>$100 per 90-day supply for non-preferred drugs<br><br>Rx Out-Of-Pocket Maximum<br>$3,000 per covered person per calendar year not to exceed $6,000 per family | **NO COVERAGE**<br><br>**NO COVERAGE** |

# Exclusions ASO

Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the Plan, the following are not covered:

Covered Expenses will not include, and no payment will be made for the following expenses incurred, unless those expenses are considered Medically Necessary.

- Expenses for charges that are not Medically Necessary, except as specified in any notification requirements shown in this plan.
- To the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- Charges made by a Hospital owned or operated by or which provides care or performs services for the United States Government: (a) unless there is a legal obligation to pay such charges whether or not there is insurance; or (b) if such charges are directly related to a military-service connected Injury or Sickness.
- For or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing, toileting or other non-Medically Necessary self-care activities, homemaker services and services primarily for rest domiciliary or convalescent care.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatoloty or psychosocial complaints related to one's appearance and determined not to be Medically Necessary. However, reconstructive surgery is covered as provided under Covered Expenses and for the purposes of this exclusion the term cosmetic surgery or therapy shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part.
- Macromastia or gynecomastia surgeries; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; orthognathic surgeries; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; extracorporeal shock wave lithotripsy for musculoskeletal and orthopedic conditions.
- For or in connection with treatment of the teeth or peridontium unless such expenses are incurred for: (a) charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth, provided a continuous course of dental treatment started within 6 months of the accident; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery, or (d) charges made by a Physician for any of the following Surgical Procedures: excision of epulis; removal of residual root (when performed by a Dentist other than the one who extracted the tooth); intraoral drainage of acute alveolar abscess with cellulitis; alveolectomy; gingvectomy, for gingivitis or periodontitis.
- For medical and surgical services intended for the treatment or control of obesity, unless Medically Necessary. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guidelines to be covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of this condition. Clinically severe obesity is defined by the NHLBI as a BMMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded: (a) medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and (b) weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalizations not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any medications, drugs, services or supplies for the treatment of female sexual dysfunction and male impotence, such as, but not limited to, anorgasmy, and premature ejaculation.
- For Infertility Services, including infertility drugs; surgical or medical treatment programs for infertility (such as in vitro fertilization, gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], or any variations of this procedures); and artificial insemination (including donor fees and any costs associated with the collection, washing, preparation, or storage of sperm). Cryopreservation of donor sperm or eggs is also excluded form coverage.
- For amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavior training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing unless determined by the utilization review Physician to be Medically Necessary.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment or an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Medical benefits for eyeglasses, contact lenses, or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames, or contact lenses that follows keratoconus or cataract surgery.
- Charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- All non injectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership cost or fees associated with health clubs, weight loss programs and smoking cessations programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids and nutritional formulae (except as described in **Covered Expenses**).
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations and telemedicine.
- Massage therapy.
- For charges which would not have been made if the person had no health benefits.
- To the extent that they are more than Reasonable and Customary charges.
- Expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- To the extent of the exclusions imposed by any notification requirement shown in this plan.
- Elective and non-elective abortions.
- Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.