UnitedHealthcare®
A UnitedHealth Group Company

Archdiocese of St. Louis Standard Plan

UnitedHealthcare *Choice Plus*

As part of our commitment to keeping you in control of your health care decisions, our Choice Plus plan gives you the freedom to see any doctor in the Choice network, including specialists, without a referral. You can even visit any out-of-network physician and still enjoy your benefits with somewhat higher deductibles and copayments.

With our Choice Plus plan, the vast majority of your health care needs are covered with less expense to you when you visit a network doctor or facility. Plus, when you visit network doctors and hospitals, there aren't any claim forms or bills to worry about.

Some of the Important Benefits of Our Choice Plus Plan for Covered Services:

Visit any doctor in the Choice network in your area, including specialists, without designating a primary physician.

Visit any network hospital in your area.

Emergencies are covered anywhere in the world.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery, when covered health services are provided.

You can choose to seek services outside our network normally at a higher copayment and/or deductible.

Prenatal care is included.

Routine check-ups are covered at no cost to the participant. Childhood and Adult immunizations are covered at no cost to the participant. Mammograms are covered at no cost to the participant.

Pap smears are covered at no cost to the participant.

Our Care Coordination[SM] services are available to help identify and prevent delays in care for those who might need specialized help.

Archdiocese of St. Louis

For information about these plan benefits, please call Member Services at 888-332-8885

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
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 Summary Plan Description (SPD) that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Plan Document, the Plan Document shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description. Network health care services under this benefit plan are covered only when provided, arranged or authorized by a Network Physician. 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. *Prior notification is required for certain services from non-Network providers.	**Annual Deductible:** $1,000 per Covered Person per calendar year, not to exceed $2,000 for all Covered Persons in a family. Copayments do not apply to the deductible **Out-of-Pocket Maximum:** $4,000 per Covered Person, per calendar year, not to exceed $8,000 for all Covered Persons in a family. Copayments, Coinsurance and Deductible accumulate towards the Out-of-Pocket Maximum. **Maximum Policy Benefit:** No Maximum Policy Benefit.	**Annual Deductible:** $2,000 per Covered Person per calendar year, not to exceed $4,000 for all Covered Persons in a family. Copayments do not apply to the deductible **Out-of-Pocket Maximum:** $8,000 per Covered Person, per calendar year, not to exceed $16,000 for all Covered Persons in a family. Copayments, Coinsurance and Deductible accumulate towards the Out-of-Pocket Maximum. **Maximum Policy Benefit:** No Maximum Policy Benefit.
	You are Responsible For:	You are Responsible For:
1. Ambulance Services — Emergency Only	Ground Transportation: 20% of Eligible Expenses Air Transportation: 20% of Eligible Expenses	Same as Network Benefit
2. Dental Services — Accident only	*20% of Eligible Expenses *Prior notification is required before follow-up treatment begins.	Same as Network Benefit
3. Durable Medical Equipment	*20% of Eligible Expenses	*40% of Eligible Expenses
4. Emergency Health Services	$150 Copayment Copay waived if admitted	Same as Network Benefit *Prior notification is required if results in an Inpatient Stay
5. Home Health Care Network and Non-Network Benefits are limited to 100 visits for skilled care services per calendar year.	20% of Eligible Expenses	*40% of Eligible Expenses
6. Hospice Care	20% of Eligible Expenses	*40% of Eligible Expenses
7. Hospital — Inpatient Stay	20% of Eligible Expenses	*40% of Eligible Expenses
8. Injections Received in a Physician's Office	$30 Copayment per visit	40% per injection
9. Maternity Services	Same as any other illness	Same as any other illness *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery
10. Outpatient Surgery	20% of Eligible Expenses	40% of Eligible Expenses
Outpatient Diagnostic Services		
Lab and Radiology/ X-ray	No Copayment	40% of Eligible Expenses
Mammography Testing	No Copayment	40% of Eligible Expenses
Outpatient Diagnostic/ Therapeutic Services- CT scans, Pet Scans and Nuclear Medicine	20% of Eligible Expenses	40% of Eligible Expenses

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11. Physician's Office Services	$30 Copayment per visit 100% for Preventive Services, No Copayment	40% of Eligible Expenses
12. Professional Fees for Surgical and Medical Services	20% of Eligible Expenses	40% of Eligible Expenses
13. Prosthetic Devices	20% of Eligible Expenses	40% of Eligible Expenses
14. Reconstructive Procedures	Same as any other illness	*Same as any other illness
15. Rehabilitation Services — Outpatient Therapy Benefits for Habilitative Services are subject to the limits as stated in this benefit section.	$30 Copayment per visit	40% of Eligible Expenses
16. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per confinement.	20% of Eligible Expenses	*40% of Eligible Expenses
17. Transplantation Services	*20% of Eligible Expenses	*40% of Eligible Expenses
18. Urgent Care Center Services	$50 Copayment per visit	40% of Eligible Expenses
Additional Benefits		
TMJ (Temporomandibular Joint Dysfunction) Only Non-Surgical treatment limited to $1,000 per calendar year.	20% of Eligible Expenses	40% of Eligible Expenses
Mental Health and Substance Abuse Services — Outpatient	$30 Copayment per visit	40% of Eligible Expenses
Mental Health and Substance Abuse Services — Inpatient and Intermediate Pre-Service Notification Required.	20% of Eligible Expenses	40% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to $1,000 per calendar year.	20% of Eligible Expenses	40% of Eligible Expenses
Natural Family Planning	$0 Copayment per visit	0% of Eligible Expenses
Prescription Drugs Prescription drugs purchased at a retail pharmacy with a medical card and through mail order pharmacy. Pharmacy copayments accumulate towards Medical Out-of-Pocket Maximum.	**Retail - 30 day limit** $10 copayment—Tier 1 $35 copayment—Tier 2 $50 copayment—Tier 3 **Mail Order - 90 day limit** $20 copayment—Tier 1 $70 copayment—Tier 2 $100 copayment—Tier 3	**Same as In-Network** **Not Covered**

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

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aroma therapy; 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, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of your SPD 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, 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. 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); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

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, gauze and dressings, syringes and diabetic test strips. Tubings and masks are not covered except when used with Durable Medical Equipment as described in your SPD.

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. Treatment of insomnia and other sleep disorders, dementia, 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 determined by the Mental Health/Substance Abuse Designee, including, but not limited to, conduct and impulse control disorders; personality disorder; and paraphilias.

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 the Mental Health/Substance Abuse Designee. Residential treatment services. Services for the treatment of mental illness or mental health conditions and substance abuse services and chemical dependency services that the Enrolling Group has elected to provide through a separate benefit plan.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups.

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.)

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.

L. Reproduction

Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization and voluntary sterilization. Contraceptive supplies or services. Health services and associated expenses for elective abortion. Elective abortion, which means the directly intended termination of pregnancy before viability (including the interval between conception and implantation of the embryo) or the directly intended destruction of a viable fetus and which includes any procedure whose sole immediate effect is the termination of pregnancy before viability. Fetal reduction surgery. Health Services associated with the use of non-surgical or drug induced Pregnancy termination.

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. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in your SPD. 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 your SPD.

O. 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.

P. Vision and Hearing

Purchase cost of eye glasses or contact lenses. Fitting charge for 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.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service — see definition in your SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan Document, 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 Plan Document ends, including health services for medical conditions arising prior to the date your coverage under the Plan Document 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 Plan Document.

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 Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

Non-surgical treatment of obesity (including morbid obesity).

Sex transformation operations; treatment of benign gynecosmastia (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; 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.

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 your Summary Plan Description 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 Plan Document, the Plan Document prevails. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.