MEDICAL INSURANCE

Side by Side Comparison:
The following comparison chart reflects In-Network coverage only. For Out-of-Network descriptions, please refer to the following Summary of Benefits for each plan. Co-pays, deductibles, Annual OOP maximum or applicable percentages are the member's responsibility. Group Number: 906136

OUT OF POCKET COSTS	UHC CHOICE PLUS PPO PLAN IN-NETWORK	UHC CHOICE PLUS HDHP PLAN IN-NETWORK
Annual Deductible	$3,000 Individual $6,000 Family	$3,200 Individual $6,000 Family
Annual Out-of-Pocket (OOP) Maximum	$4,000 Individual $8,000 Family	$4,000 Individual $8,000 Family
Maximum Lifetime Benefits	Unlimited	Unlimited
DOCTOR'S OFFICE		
Virtual Office Visit **Designated Virtual Network Provider**	$30 copay	10% coinsurance after deductible (estimated $49 charge)
Primary Care Office Visit	$30 copay	10% coinsurance after deductible
Specialist Office Visit	$50 copay	10% coinsurance after deductible
Annual Wellness Exam	Plan Pays 100%, no deductible	Plan Pays 100%, no deductible
HOSPITAL SERVICES		
Urgent Care Provider	Plan pays100% after $75 copay	10% coinsurance after deductible
Emergency Room	$250 copay* per visit, deductible doesn't apply	10% coinsurance after deductible
Hospital Care - Inpatient	Plan pays 100% after deductible	10% coinsurance after deductible
Diagnostic Lab and X-Ray— Outpatient	Plan pays 100%, no deductible	10% coinsurance after deductible
Major Diagnostic (CT, PET, MRI)	Plan pays 100% after deductible	10% coinsurance after deductible
Maternity: Office Visits	No Charge	No Charge
Delivery-professional services	Plan pays 100% after deductible	10% coinsurance after deductible
Delivery-facility services	Plan pays 100%, no deductible	10% coinsurance after deductible
Home Health Care (60 visits/year)	Plan pays 100% after deductible	10% coinsurance after deductible
Hospice Care	Plan pays 100% after deductible	10% coinsurance after deductible
Outpatient Rehabilitation Therapy (limited visits/see plan summary)	Plan pays 100% after $50 copay	10% coinsurance after deductible
Chemical Dependency	*Preauthorization Required*	*Preauthorization Required*
Outpatient Services	$50 copay; deductible doesn't apply	10% coinsurance after deductible
Inpatient Services	Plan pays 100% after deductible	10% coinsurance after deductible
Mental Health Outpatient Services	$50 copay	10% coinsurance after deductible
Mental Health Inpatient Services	Plan pays 100% after deductible	10% coinsurance after deductible
PRESCRIPTION DRUGS GENERIC	**PPO DEDUCTIBLE DOESN'T APPLY**	**HDHP AFTER DEDUCTIBLE**
Tier 1 – Your Lowest Cost Option	Retail: $10 copay / Mail-Order: $30 copay	Retail: $10 copay / Mail-Order: $30 copay
Tier 2 – Your Mid-Range Cost Option	Retail: $40 copay / Mail-Order: $120 copay	Retail: $40 copay / Mail-Order: $120 copay
Tier 3 – Your Mid-Range Cost Option	Retail: $70 copay / Mail-Order: $210 copay	Retail: $70 copay / Mail-Order: $210 copay

*Waived if admitted

UHC CHOICE PLUS PPO PLAN

	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE
Annual Deductible	$3,000 Individual $6,000 Family	$5,000 Individual $10,000 Family
Annual Out-of-Pocket Maximum	$4,000 Individual $8,000 Family	$15,000 Individual** $30,000 Family**
Maximum Lifetime Benefits	Unlimited	Unlimited
DOCTOR'S OFFICE	**IN-NETWORK COVERAGE**	**OUT-OF-NETWORK COVERAGE**
Virtual Office Visit	$30 copay	Out-of-Network Not Available
Primary Care Office Visit	$30 copay	Plan pays 50% after deductible
Specialist Office Visit	$50 copay	Plan pays 50% after deductible
Annual Wellness Exam	Plan pays 100%, no deductible	Not Covered
Preventative screening/immunization	No Charge	Not Covered
COMMON MEDICAL SERVICES	**IN-NETWORK COVERAGE**	**OUT-OF-NETWORK COVERAGE**
Emergency Room Services	$250 copay* per visit, deductible doesn't apply	$250 copay per visit, deductible doesn't apply
Emergency Medical Transportation	Plan pays100% after deductible	50% coinsurance after deductible
Urgent Care Provider	Plan pays100% after $75 copay	50% coinsurance after deductible
Hospital Care - Inpatient	Plan pays 100% after deductible	50% coinsurance after deductible
Diagnostic Lab and X-Ray— Outpatient	Plan pays 100%, no deductible	50% coinsurance after deductible
Major Diagnostic (CT, PET, MRI)	Plan pays 100% after deductible	50% coinsurance after deductible
Maternity: Office Visits	$50 copay	50% coinsurance after deductible
Delivery-professional services	Plan pays 100% after deductible	50% coinsurance after deductible
Delivery-facility services	Plan pays 100%, no deductible	50% coinsurance after deductible
Home Health Care (60 visits/year)	Plan pays 100% after deductible	50% coinsurance after deductible
Hospice Care	Plan pays 100% after deductible	50% coinsurance after deductible
Outpatient Rehabilitation Therapy (limited visits/see plan summary)	50 copay per visit deductible does not apply	50% coinsurance after deductible
Chemical Dependency	*Preauthorization Required*	*Preauthorization Required*
Outpatient Services	$50 copay; deductible doesn't apply	50% coinsurance after deductible
Inpatient Services	Plan pays 100% after deductible	50% coinsurance after deductible
Mental Health Outpatient Services	Plan pays 100% after deductible	50% coinsurance after deductible
Mental Health Inpatient Services	$50 copay	50% coinsurance after deductible
PRESCRIPTION DRUGS GENERIC	**DEDUCTIBLE DOES NOT APPLY**	**DEDUCTIBLE DOES NOT APPLY**
Tier 1 – Your Lowest Cost Option	Retail: $10 copay / Mail-Order: $30 copay	Retail: $10 copay, then 30% coinsurance
Tier 2 – Your Mid-Range Cost Option	Retail: $40 copay / Mail-Order: $120 copay	Retail: $40 copay, then 30% coinsurance
Tier 3 – Your Mid-Range Cost Option	Retail: $70 copay / Mail-Order: $210 copay	Retail: $70 copay, then 30% coinsurance

*Waived if admitted.

**Please note, that when utilizing an out of network (OON) provider, you may be billed by your OON provider for any amount not covered by UHC and the amount that is billed beyond the covered amounts do not count towards your OON out of pocket maximum. This is called balance billing. The balance billed amounts are your financial responsibility. Please note, that most ambulance services for ER purposes are considered out of network. UHC will pay the ambulance services as if they were in- network, but the patient can still be balanced billed from the provider.

UHC CHOICE PLUS HIGH DEDUCTIBLE HEALTH PLAN – (HDHP)

	IN-NETWORK COVERAGE	OUT-OF-NETWORK COVERAGE
Annual Deductible	$3,200 Individual $6,000 Family	$6,000 Individual $12,000 Family
Annual Out-of-Pocket Maximum	$4,000 Individual $8,000 Family	$12,000 Individual* $24,000 Family*
Maximum Lifetime Benefits	Unlimited	Unlimited
DOCTOR'S OFFICE	**IN-NETWORK COVERAGE**	**OUT-OF-NETWORK COVERAGE**
Virtual Office Visit	10% coinsurance after deductible	Out-of-Network Not Available
Primary Care Office Visit	10% coinsurance after deductible	50% coinsurance after deductible
Specialist Office Visit	10% coinsurance after deductible	50% coinsurance after deductible
Annual Wellness Exam	No Charge	50% coinsurance after deductible
Preventative screening/immunization	No Charge	50% coinsurance after deductible
COMMON MEDICAL SERVICES	**IN-NETWORK COVERAGE**	**OUT-OF-NETWORK COVERAGE**
Emergency Room Services	10% coinsurance after deductible	10% coinsurance after deductible**
Emergency Medical Transportation	10% coinsurance after deductible	10% coinsurance after deductible**
Urgent Care Provider	10% coinsurance after deductible	50% coinsurance after deductible
Hospital Care - Inpatient	10% coinsurance after deductible	50% coinsurance after deductible
Diagnostic Lab and X-Ray— Outpatient	10% coinsurance after deductible	50% coinsurance after deductible
Major Diagnostic (CT, PET, MRI)	10% coinsurance after deductible	50% coinsurance after deductible
Maternity: Office Visits	10% coinsurance after deductible	50% coinsurance after deductible
Delivery-professional services	10% coinsurance after deductible	50% coinsurance after deductible
Delivery-facility services	10% coinsurance after deductible	50% coinsurance after deductible
Home Health Care (60 visits/year)	10% coinsurance after deductible	50% coinsurance after deductible
Hospice Care	10% coinsurance after deductible	50% coinsurance after deductible
Outpatient Rehabilitation Therapy (limited visits/see plan summary)	10% coinsurance after deductible	50% coinsurance after deductible
Chemical Dependency	*Preauthorization Required*	*Preauthorization Required*
Outpatient Services	10% coinsurance after deductible	50% coinsurance after deductible
Inpatient Services	10% coinsurance after deductible	50% coinsurance after deductible
Mental Health Outpatient Services	10% coinsurance after deductible	50% coinsurance after deductible**
Mental Health Inpatient Services	10% coinsurance after deductible	50% coinsurance after deductible**
PRESCRIPTION DRUGS GENERIC	All **copayment** & **coinsurance** costs below are after your **deductible** has been met	
Tier 1 – Your Lowest Cost Option	Retail: $10 copay / Mail-Order: $30 copay after deductible	Retail: $10 copay, then 30% coinsurance
Tier 2 – Your Mid-Range Cost Option	Retail: $40 copay / Mail-Order: $120 copay after deductible	Retail: $40 copay, then 30% coinsurance
Tier 3 – Your Mid-Range Cost Option	Retail: $70 copay / Mail-Order: $210 copay after deductible	Retail: $70 copay, then 30% coinsurance

*Please note, that when utilizing an out of network (OON) provider, you may be billed by your OON provider for any amount not covered by UHC and the amount that is billed beyond the covered amounts do not count towards your OON out of pocket maximum. This is called balance billing. The balance billed amounts are your financial responsibility. **Network deductible applies. Please note, that most ambulance services for ER purposes are considered out of network. UHC will pay the ambulance services as if they were in-network, but the patient can still be balance billed from the provider.