Medical Plan Highlights

	UHC CDHP w/ HSA		UHC Choice Plus Medical Plan 1		UHC Choice Plus Medical Plan 2		UHC Out-of-Area Plan 1	UHC Out-of-Area Plan 2
Features	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**
Annual Deductible • Individual • Family (Associate + 1 or more)	$1,500 $3,000	$3,000 $6,000	$1,000 $2,000	$2,000 $4,000	$500 $1,000	$1,000 $2,000	$1,000 $2,000	$500 $1,000
Annual Out-of-Pocket Maximum (includes deductible) • Individual • Family (Associate + 1 or more)	$6,000 $12,000	$12,000 $24,000	$5,000 $10,000	$10,000 $20,000	$2,500 $5,000	$5,000 $10,000	$5,000 $10,000	$2,500 $5,000
Coinsurance (percentage you pay)	30%	50%	30%	50%	10%	50%	30%	10%
PCP Office Visit (no charge for routine physicals, immunizations)	30% after deductible	50% after deductible	$25 copay (no deductible)	50% after deductible	$20 copay (no deductible)	50% after deductible	$25 copay (no deductible)	$20 copay (no deductible)
Specialist Office Visit	30% after deductible	50% after deductible	$45 copay (no deductible)	50% after deductible	$40 copay (no deductible)	50% after deductible	$45 copay (no deductible)	$40 copay (no deductible)
Hospital Services • Inpatient • Outpatient	30% after deductible 30% after deductible	50% after deductible 50% after deductible	$400 copay, then 30% 30% after deductible	$400 copay, then 50% 50% after deductible	$200 copay, then 10% 10% after deductible	$200 copay, then 50% 50% after deductible	$400 copay, then 30% 30% after deductible	$200 copay, then 10% 10% after deductible
Emergency Services • Hospital ER • Ambulance	30% after deductible 30% after deductible	50% after deductible 50% after deductible	$250 copay (waived if admitted) 30% (no deductible)	$250 copay (waived if admitted) 30% (no deductible)	$250 copay (waived if admitted) 10% (no deductible)	$250 copay (waived if admitted) 10% (no deductible)	$250 copay (waived if admitted) 30% (no deductible)	$250 copay (waived if admitted) 10% (no deductible)
Urgent Care Facility (freestanding)	30% after deductible	50% after deductible	$45 copay (no deductible)	50% after deductible	$40 copay (no deductible)	50% after deductible	$45 copay (no deductible)	$40 copay (no deductible)
Non-Routine Lab/X-rays (no charge for preventive/routine lab/X-rays)	30% after deductible	50% after deductible	30% after deductible $100 copay for MRI, MRA, CT & PET Scan	50% after deductible	10% after deductible $100 copay for MRI, MRA, CT & PET Scan	50% after deductible	30% after deductible $100 copay for MRI, MRA, CT & PET Scan	10% after deductible $100 copay for MRI, MRA, CT & PET Scan
Mental Health & Substance Abuse • Inpatient • Outpatient	30% after deductible 30% after deductible	50% after deductible 50% after deductible	$400 copay, then 30% $25 copay (no deductible)	$400 copay, then 50% 50% after deductible	$200 copay, then 10% $20 copay, (no deductible)	$200 copay, then 50% 50% after deductible	$400 copay, then 30% $25 copay (no deductible)	$200 copay, then 10% $20 copay, (no deductible)
Durable Medical Equipment	30% after deductible	50% after deductible	30% after deductible	50% after deductible	10% after deductible	50% after deductible	30% after deductible	10% after deductible
Prescription Drugs, Retail Pharmacy (30-day supply)* • Generic • Brand name, formulary • Brand name, non-formulary	After Ded. & 30% Coinsurance $25 Max $25 min; $50 max $50 min; $100 max	Not Covered	$10 20% ($25 min; $50 max) 30% ($50 min; $100 max)	Not Covered	$10 20% ($25 min; $50 max) 30% ($50 min; $100 max)	Not Covered	$10 20% ($25 min; $50 max) 30% ($50 min; $100 max)	
Prescription Drugs, Mail Order (90-day supply or CVS Pharmacy)* • Generic • Brand name, formulary • Brand name, non-formulary	After Ded. & 30% Coinsurance $50 max $50 min; $100 max $100 min; $200 max	Not Covered	$20 20% ($50 min; $100 max) 30% ($100 min; $200 max)	Not Covered	$20 20% ($50 min; $100 max) 30% ($100 min; $200 max)	Not Covered	$10 20% ($25 min; $50 max) 30% ($50 min; $100 max)	

*Not covered if you use a non-participating pharmacy