Comparison of UnitedHealthCare Plans for Full-time Faculty and Administrative Staff

This is intended to provide a general overview of benefits. Please refer to each plan's Summary of Benefits and Coverage (SBC) and Summary Plan Description for additional information.

	Choice Plus 1000		Choice EPO	High Deductible Health Plan	
PLAN FEATURES	**In-Network**	**Out-of-Network**	**In-Network**	**In-Network**	**Out-of-Network**
Annual Calendar Year Deductible Individual Family	 $100 $200	 $1,000 $2,000	 $100 $200	 $2,000 $4,000	 $2,000 $4,000
Coinsurance*	None	30%	None	10%	30%
Out-of-Pocket Maximum** Individual Family	 $4,000 $8,000	 $4,000 $8,000	 $3,500 $7,000	 $3,000 $6,000	 $5,000 $10,000
Lifetime Maximum Plan Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Primary Care Physician Selection	Not required	Not applicable	Not required	Not required	Not applicable
Specialist Referral Requirement	None	None	None	None	None
Precertification Requirements	Not required	Member responsible for hospital admissions and certain other services	Not required	Not required	Member responsible for hospital admissions and certain other services
Type of Service					
Physician Services Performed in an Office Setting (Includes Mental Health Practitioners)	Covered at 100% after Deductible and $30 copayment - Primary Care Physician Office Visit Covered at 100% after Deductible and $50 copayment - Specialist Office Visit	30% of UCR* after deductible is met	Covered at 100% after Deductible and $25 Copayment - Primary Care Physician Office Visit Covered at 100% after Deductible and$40 Copayment - Specialist Office Visit	10% after deductible is met	30% of UCR* after deductible is met
Preventive Care (e.g. annual adult physical, well child care, gynecological exams)* **	Covered 100%	30% of UCR* after deductible is met	Covered 100%	Covered 100%; deductible waived	30% of UCR* after deductible is met
Inpatient Hospitalization	Covered at 100% after Deductible and $200 copayment****	30% of UCR* after deductible is met	Covered 100% after Deductible and $125 copayment ****	10% after deductible is met	30% of UCR* after deductible is met
Outpatient Hospitalization	Covered at 100% after Deductible and $100 copayment****	30% of UCR* after deductible is met	Covered at 100% after Deductible and $100 copayment ****	10% after deductible is met	30% of UCR* after deductible is met
Maternity	Covered at 100% after Deductible and $30 Copayment for initial office visit,	30% of UCR* after deductible is met	Covered at 100% after Deductible and $25 Copayment for initial office visit	10% after deductible is met	30% of UCR* after deductible is met
Emergency Room Care	$100 Copayment (waived if admitted) after deductible is met		$100 Copayment (waived if admitted) after deductible is met	10% after deductible is met	
Retail Pharmacy Benefit (up to a 30-day or one month supply)	$15 Copayment Tier 1 medications $50 Copayment Tier 2 medications $100 Copayment Tier 3 medications	Not applicable	$15 Copayment Tier 1 medications $50 Copayment Tier 2 medications $100 Copayment Tier 3 medications	After deductible is met: $15 Copayment Tier 1 medications $50 Copayment Tier 2 medications $100 Copayment Tier 3 medications	Not applicable
Mail Order Pharmacy Benefit (up to a 90-day or 3 month supply)	2.5x Retail Pharmacy Copayment	Not applicable	2.5x Retail Pharmacy Copayment	After deductible is met: 2.5x Retail Pharmacy Copayment after deductible is met	Not applicable
Routine Vision Exams and Eyewear	Coverage provided by UnitedHealthcare. See Vision Benefits Summary for details on coverage and costs.				

* The percentage of the Usual and Customary Rate (UCR). You are also responsible for amounts charged in excess of the UCR. **Includes annual deductible. ***Subject to age and gender guidelines. ****Waived if readmitted in 90 days.