

# Medical Insurance: Choice Plus Plan 004 At-A-Glance

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your United Healthcare medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact United Healthcare's Customer Service at (800) 357-0978.

Network	Choice Plus	
<b>Calendar Year Deductible (CYD)</b>	<b>In Network</b>	<b>Out of Network</b>
Single	\$500	\$1,000
Family	\$1,000	\$2,000
<b>Coinsurance</b>	<b>In Network</b>	<b>Out of Network</b>
Member Responsibility	20%	30%
<b>Calendar Year Out-of-Pocket Limit</b>	<b>In Network</b>	<b>Out of Network</b>
Single	\$3,000	\$6,000
Family	\$6,000	\$12,000
What Applies to the Out-of-Pocket Limit	Deductible, Coinsurance and Copays	
<b>Physician Services</b>	<b>In Network</b>	<b>Out of Network*</b>
Physician Office Visit	\$25 Copay	30% After CYD
Specialist Office Visit	\$50 Copay	
<b>Diagnostic Services</b>	<b>In Network</b>	<b>Out of Network*</b>
Clinical Lab (Blood Work) at Independent Facility	No Charge	30% After CYD
X-rays at Independent Facility	No Charge	
Advanced Imaging (MRI, PET, CT)	20% After CYD	
<b>Hospital Services</b>	<b>In Network</b>	<b>Out of Network*</b>
Inpatient	20% After CYD	30% After CYD
Outpatient Surgery	20% After CYD	30% After CYD
Physician Services at Hospital or Outpatient Facility	20% After CYD	30% After CYD
Emergency Room (Per Visit; Waived if Admitted)	\$150 Copay	\$150 Copay
Urgent Care Center (Per Visit)	\$50 Copay	30% After CYD
<b>Mental Health / Alcohol &amp; Substance Abuse</b>	<b>In Network</b>	<b>Out of Network*</b>
Inpatient (Prior Authorization Required)	20% After CYD	30% After CYD
Outpatient (Per Visit; Prior Authorization Required)	\$25 Copay	
<b>Prescription Drugs (Rx)</b>	<b>In Network</b>	<b>Out of Network*</b>
Tier 1	\$10 Copay	\$10 Copay
Tier 2	\$35 Copay	\$35 Copay
Tier 3	\$60 Copay	\$60 Copay
Mail Order Drug (90 Day Supply)	2.5x Retail Copay	Not Covered

## \*Out-Of-Network Balance Billing

For information regarding Out-of-Network Balance Billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).

# Medical Insurance: Choice Plus Plan 003 At-A-Glance

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your United Healthcare medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact United Healthcare's Customer Service at (800) 357-0978.

Network	Choice Plus	
<b>Calendar Year Deductible (CYD)</b>	<b>In Network</b>	<b>Out of Network</b>
Single	\$500	\$1,000
Family	\$1,000	\$2,000
<b>Coinsurance</b>	<b>In Network</b>	<b>Out of Network</b>
Member Responsibility	10%	30%
<b>Calendar Year Out-of-Pocket Limit</b>	<b>In Network</b>	<b>Out of Network</b>
Single	\$2,500	\$5,000
Family	\$5,000	\$10,000
What Applies to the Out-of-Pocket Limit	Deductible, Coinsurance and Copays	
<b>Physician Services</b>	<b>In Network</b>	<b>Out of Network*</b>
Physician Office Visit	\$20 Copay	30% After CYD
Specialist Office Visit	\$40 Copay	
<b>Diagnostic Services</b>	<b>In Network</b>	<b>Out of Network*</b>
Clinical Lab (Blood Work) at Independent Facility	No Charge	30% After CYD
X-rays at Independent Facility	No Charge	
Advanced Imaging (MRI, PET, CT)	10% After CYD	
<b>Hospital Services</b>	<b>In Network</b>	<b>Out of Network*</b>
Inpatient	10% After CYD	30% After CYD
Outpatient Surgery	10% After CYD	30% After CYD
Physician Services at Hospital or Outpatient Facility	10% After CYD	30% After CYD
Emergency Room (Per Visit; Waived if Admitted)	\$150 Copay	\$150 Copay
Urgent Care Center (Per Visit)	\$50 Copay	30% After CYD
<b>Mental Health / Alcohol &amp; Substance Abuse</b>	<b>In Network</b>	<b>Out of Network*</b>
Inpatient (Prior Authorization Required)	10% After CYD	30% After CYD
Outpatient (Per Visit; Prior Authorization Required)	\$20 Copay	
<b>Prescription Drugs (Rx)</b>	<b>In Network</b>	<b>Out of Network*</b>
Tier 1	\$10 Copay	\$10 Copay
Tier 2	\$35 Copay	\$35 Copay
Tier 3	\$60 Copay	\$60 Copay
Mail Order Drug (90 Day Supply)	2.5x Retail Copay	Not Covered

## \*Out-Of-Network Balance Billing

For information regarding Out-of-Network Balance Billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).

# Medical Insurance: Choice Plus Plan 001 At-A-Glance

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefit Highlights Booklet, is your primary source of information regarding your United Healthcare medical plan. The information contained in this Booklet regarding your medical plan is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact United Healthcare's Customer Service at (800) 357-0978.

Network	Choice Plus	
<b>Calendar Year Deductible (CYD)</b>	<b>In Network</b>	<b>Out of Network</b>
Single	\$250	\$500
Family	\$500	\$1,000
<b>Coinsurance</b>	<b>In Network</b>	<b>Out of Network</b>
Member Responsibility	0%	30%
<b>Calendar Year Out-of-Pocket Limit</b>	<b>In Network</b>	<b>Out of Network</b>
Single	\$2,000	\$4,000
Family	\$4,000	\$8,000
What Applies to the Out-of-Pocket Limit	Deductible, Coinsurance and Copays	
<b>Physician Services</b>	<b>In Network</b>	<b>Out of Network*</b>
Physician Office Visit	\$15 Copay	30% After CYD
Specialist Office Visit	\$30 Copay	
<b>Diagnostic Services</b>	<b>In Network</b>	<b>Out of Network*</b>
Clinical Lab (Blood Work) at Independent Facility	No Charge	30% After CYD
X-rays at Independent Facility	No Charge	
Advanced Imaging (MRI, PET, CT)	\$100 Copay	
<b>Hospital Services</b>	<b>In Network</b>	<b>Out of Network*</b>
Inpatient	0% After CYD	30% After CYD
Outpatient Surgery	\$100 Copay	30% After CYD
Physician Services at Hospital or Outpatient Facility	0% After CYD	30% After CYD
Emergency Room (Per Visit; Waived if Admitted)	\$125 Copay	\$125 Copay
Urgent Care Center (Per Visit)	\$50 Copay	30% After CYD
<b>Mental Health / Alcohol &amp; Substance Abuse</b>	<b>In Network</b>	<b>Out of Network*</b>
Inpatient (Prior Authorization Required)	0% After CYD	30% After CYD
Outpatient (Per Visit; Prior Authorization Required)	\$15 Copay	
<b>Prescription Drugs (Rx)</b>	<b>In Network</b>	<b>Out of Network*</b>
Tier 1	\$10 Copay	\$10 Copay
Tier 2	\$35 Copay	\$35 Copay
Tier 3	\$60 Copay	\$60 Copay
Mail Order Drug (90 Day Supply)	2.5x Retail Copay	Not Covered

## \*Out-Of-Network Balance Billing

For information regarding Out-of-Network Balance Billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).