United HealthCare

Choice Plus Plan

for UNIVERSITY MEDICAL SERVICE ASSOCIATION, INC.

	Tier 1 USF	Tier 2UHC In-Network	Tier 3 UHC Out-Of-Network
Plan Features			
■ Physician Services Office Visit Copay	Copay $0	$10 Copay Per Visit	80% after Deductible
■ Specialist Copay	Copay $0	$20 Copay Per Visit	
■ Plan Coinsurance	100%	80%	80%
■ Emergency Room - Copay $0 If Admitted	100%	$50	$50
Urgent Care	100%	100%	80% after Deductible
■ Individual Deductible	Deductible $0	$250	$500
■ Family Deductible	Deductible $0	$500	$1000
■ Hospital Confinement Deductible	Deductible $0	N/A	$250
■ Non-Notification Penalty	Reduction to 50%	Reduction to 50%	Reduction to 50%
■ Individual Out-Of-Pocket	Out of Pocket $0	$2000	$4000
■ Family Out-Of-Pocket	Out of Pocket $0	$4000	$8000
■ Lifetime Maximum	Unlimited	Unlimited	Unlimited
Covered Services			
Physician Office Visits	Copay $0	$10 Copay Per Visit	80% after Deductible
■ Routine Physical Examinations	Copay $0	$10 Copay Per Visit	Not Covered
■ Diagnostic Lab & X-Ray	Copay $0	$10 Copay Per Visit	80% after Deductible
■ Eye Examination\	Copay $0	$0 Copay Per Visit	80% after Deductible
■ Injections in Doctors Office, except for immunizations	Copay $0	$10 Copay Per Visit	80% after Deductible
■ Well Child Care/Immunizations	Copay $0	$10 Copay Per Visit	Not Covered
■ Preventive Care	Copay $0	$10 Copay Per Visit	Not Covered
■ Specialist (Office Visits)	Copay $0	$20 Copay per Visit	80% after Deductible
Outpatient Diagnostic Services ■ Diagnostic, Laboratory And X-Ray	100%	80% after Deductible	80% after Deductible
Outpatient Surgery ■ Outpatient Surgical Center	100%	80% after Deductible	80% after Deductible

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Outpatient Rehabilitation (In office)			
■ Physical Therapy	Copay $0	$20 Copay	80% after Deductible
■ Occupational Therapy	100%	$20 Copay	80% after Deductible
■ Speech Therapy	100%	$20 Copay	80% after Deductible
■ Spinal Manipulation	Copay $0	$20 Copay	80% after Deductible
20 Visits Of Each Type Per Year			
Hospital Care	100%	80% after Deductible	80% after Deductible
■ Room And Board			
■ Diagnostic Laboratory And X-Ray			
■ Misc. Charges			
Professional Fees - Inpatient	100%	80% after Deductible	80% after Deductible
■ Surgeon/Physicians			
Maternity Care	100%	80% after Deductible	80% after Deductible
■ Physician Prenatal And Postnatal Care			
Emergency Care			
■ Hospital Emergency Room Care (Copay $0 If Admitted)	100%	$50 Copay	$50 Copay
■ Ambulance Services	100%	100%	100%
■ Dental- Accident only	100%	100%	100%
■ Prosthetic Devices	100%	100%	80% after Deductible

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■ **Durable Medical Equipment**	100%	100%	80% after Deductible
■ **Home Health Care** 40 Visits Per Calendar Year	100%	100%	80% after Deductible
■ **Hospice Services**	100%	100%	80% after Deductible
■ **Skilled Nursing/Extended Care Facility Services** 120 Days Per Calendar Year	100%	100%	80% after Deductible
■ **Transplant Benefits Through United Resource Networks**	100% Through The Program	100% Through The Program	80% after Deductible
■ **Mental Health/Substance Abuse Inpatient**	100%	80% after deductible	80% after deductible
■ **Outpatient**	Individual copay $0 Group Copay $0	$10 Copay	80% after deductible
Prescription Drug Services (Mandatory Generic Program in place 7/1/17)			
Retail Pharmacy:			
■ Retail Generic	$10 Copay	$10 Copay	Not Covered
■ Retail Formulary Brand	$25 copay	$25 Copay	Not Covered
■ Retail Non Formulary Brand	$40 copay	$40 Copay	Not Covered
Mail Order Drugs			
■ Mail Order Generic	$20 copay	$20 Copay	Not Covered
■ Mail Order Formulary Brand	$50 Copay	$50 Copay	Not Covered
■ Mail Order Non Formulary Brand	$80 Copay	$80 Copay	Not Covered
Network Type	Preferred Network	Preferred Network	Not Covered
Generic Drug Policy	Voluntary	Voluntary	Not Covered
Contraceptives – oral,	Covered	Covered	Not Covered

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diaphragms and self-administered injectables			

- All plan limits are combined for network and non-network services.
- Deductibles and Out of Pocket limits are separate for in network and out of network and do NOT cross apply.