# Benefit Plan Comparison

**Effective January 1, 2015**

**Group # 165058**

1-866-211-4575

**Revised September 2014**

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## United Healthcare

### Point of Service Plan

<table>
<thead>
<tr>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Design:</strong></td>
<td>The Point of Service Plan also provides benefits for network doctors/providers, hospitals and pharmacies subject to a co-pay. A Primary Care Physician election is not necessary and referrals to specialists are not required.</td>
</tr>
<tr>
<td><strong>Dependent Eligibility:</strong></td>
<td>Spouse (documented required); children to age 26, or disabled if medically certified and approved.</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible:</strong></td>
<td>None.</td>
</tr>
<tr>
<td><strong>Coinsurance Provision:</strong></td>
<td>Plan pays 100% except where noted co-pays apply.</td>
</tr>
<tr>
<td><strong>Maximum Calendar Year Out of Pocket:</strong></td>
<td>$5,000 individual/$10,000 family (combined with pharmacy). Plan then pays 100% for remainder of the calendar year.</td>
</tr>
<tr>
<td><strong>Lifetime Maximum:</strong></td>
<td>No maximum.</td>
</tr>
<tr>
<td><strong>Physician Services:</strong></td>
<td>No charge if the result of an accident. Benefits limited to in-network only. Prior authorization required. Cosmetic correction is not covered.</td>
</tr>
<tr>
<td><strong>Accidental Dental Care:</strong></td>
<td>Covered at 90% of contracted rate, after deductible is met until maximum out-of-pocket is reached. Benefits limited to in-network only. Prior authorization required. Cosmetic correction is not covered.</td>
</tr>
<tr>
<td><strong>Chiropractic Care:</strong></td>
<td>Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached. Up to 30 visits per calendar year. In and out of network visits combined. Pre-authorization for services required; managed by ACN. Treatment plan required.</td>
</tr>
<tr>
<td><strong>MRI, CAT or Pet scan:</strong></td>
<td>Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached.</td>
</tr>
<tr>
<td><strong>Occupational Therapy:</strong></td>
<td>Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached. Up to 30 visits per calendar year. In and out of network visits combined. Pre-authorization for services and treatment plan required. May be determined by appropriate network.</td>
</tr>
<tr>
<td><strong>Office Visits: (Primary &amp; Specialist)</strong></td>
<td>Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached.</td>
</tr>
<tr>
<td><strong>Outpatient Surgical Procedure:</strong></td>
<td>$200 co-pay.</td>
</tr>
</tbody>
</table>

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This benefit comparison is intended only to highlight the plan design and should not be relied upon to fully determine coverage. If this comparison conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail.
### In Network vs. Out of Network

#### Physical Therapy:
- **$20 co-pay. Up to 120 visits per calendar year.** In and out of network visits combined. Pre-authorization for services and treatment plan required.
- Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached. Up to 120 visits per calendar year. In and out of network visits combined. Pre-authorization for services and treatment plan required.

#### Prenatal and Postnatal Care:
- **$0 co-pay for all prenatal care visits and ultrasounds.**
- Covered in full for all prenatal care visits. Ultrasounds covered at 90% of contracted rate, after deductible is met until maximum out-of-pocket is reached.

#### Preventive Care:
- **$0 co-pay (includes well adult, well woman, well baby and well child preventive care).**
- Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached.

#### Speech Therapy:
- **$20 co-pay. Up to 30 visits per calendar year.** In and out of network visits combined. Limited to certain conditions. Pre-authorization for services and treatment plan required.
- Covered at 90% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached. Up to 30 visits per calendar year. In and out of network visits combined. Limited to certain conditions. Pre-authorization for services and treatment plan required.

#### Urgent Care Center:
- **$50 co-pay.**
- Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached.

#### Vision Care:
- **$20 co-pay. One routine eye exam every 24 months.** Please see Health Allies Discount Program on [www.myuhc.com](http://www.myuhc.com) for discounts on glasses and/or contacts.
- Covered at 90% of contracted rate, after deductible is met until maximum out-of-pocket is reached. One routine eye exam every 24 months. Please see Health Allies Discount Program on [www.myuhc.com](http://www.myuhc.com) for discounts on glasses and/or contacts.

#### X-Ray/Laboratory Exams:
- **Covered in full.**
- Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached.

### Hospital Services:

#### Notification
- **Notification for inpatient and outpatient services/surgical procedures may be required based on diagnosis. Participating providers are responsible for notification. Please consult SPD for further details.**

#### Emergency Services:
- **$100 co-pay for emergency room visit. Co-pay waived if admitted to hospital. Medical care and treatment provided after the sudden onset of a medical condition must be severe enough that lack of immediate medical attention could reasonably result in placing the patient’s health in serious jeopardy. Non-emergency care provided in the ER is not covered.**
- Covered at 90% of contracted rate, after deductible is met until maximum out-of-pocket is reached. Medical care and treatment provided after the sudden onset of a medical condition must be severe enough that lack of immediate medical attention could reasonably result in placing the patient's health in serious jeopardy. Non-emergency care provided in the ER is not covered.

#### Inpatient Coverage

#### Room and Board
- **$500 co-pay for each hospitalization, then covered in full.**
- Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached. Notification required. $500 non-notification penalty for out of network services.

#### Surgery
- **Covered in full.**
- Covered at 90% of contracted rate, after deductible is met until maximum out-of-pocket is reached.

#### Anesthesia
- **Covered in full.**
- Covered at 90% of contracted rate, after deductible is met until maximum out-of-pocket is reached.

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### Point of Service Plan

<table>
<thead>
<tr>
<th>Prescription Coverage</th>
<th>In Network</th>
<th>Out of Network</th>
<th>Deductible-based Plan</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$10 co-pay (if less than $10, actual cost of prescription), 25% co-insurance (minimum $25 to maximum $50) for preferred brand name drugs, 35% co-insurance (minimum $40 to maximum $80) for non-preferred brand name drugs. Up to 30-day supply. Certain specialty medications may require refills through United Healthcare's Specialty Pharmacy. Member pays twice the appropriate co-pay for mail order services, up to 90-day supply. Pharmacy co-pay accumulation to a maximum out of pocket of $5,000 individual / $10,000 family (combined with medical), then the plan pays 100%.</td>
<td>Not covered.</td>
<td>Covered at 90% of the retail network pharmacy's reasonable and customary charge, after deductible is met until maximum out-of-pocket is reached. Up to 30-day supply. Certain specialty medications may require refills through United Healthcare's Specialty Pharmacy. Mail order services available, up to 90-day supply.</td>
<td>Not covered.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mental Health**

**Notification**

Notification for inpatient and outpatient services/surgical procedures may be required based on diagnosis. Participating providers are responsible for notification. Please consult SPD for further details. Call Member services at 1-866-211-4575 or log onto www.myuhc.com.

**Inpatient**

$500 co-pay for each hospitalization, then covered in full. Notification required by calling United Behavioral Health (1-866-211-4575).

Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached. Notification required by calling United Behavioral Health (1-866-211-4575). $500 non-notification penalty for out of network services.

Covered at 90% of contracted rate, after deductible is met until maximum out-of-pocket is reached. Notification required by calling United Behavioral Health (1-866-211-4575). $500 non-notification penalty for out of network services.

**Outpatient**

$20 co-pay.

Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached.

Covered at 90% of contracted rate, after deductible is met until maximum out-of-pocket is reached.

Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached.

**Substance Abuse (Alcohol and Drug)**

**Notification**

Call must be made to medical management within one working day of confinement for approval. Notification may be required based on diagnosis. Please consult SPD for further details. Call Member services at 1-866-211-4575 or log onto www.myuhc.com.

**Inpatient**

$500 co-pay for each hospitalization, then covered in full. Notification required by calling United Behavioral Health (1-866-211-4575).

Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached. Notification required by calling United Behavioral Health (1-866-211-4575). $500 non-notification penalty for out of network services.

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**Outpatient**

$20 co-pay.

Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached.

Covered at 90% of contracted rate, after deductible is met until maximum out-of-pocket is reached.

Covered at 70% of reasonable and customary, after deductible is met until maximum out-of-pocket is reached.

**Out of Country Benefits:**

**Emergency**

$100 co-pay (waived if admitted). Call 1-866-211-4575 as soon as possible to notify United Healthcare of the emergency. Medical care and treatment provided after the sudden onset of a medical condition must be severe enough that lack of immediate medical attention could reasonably result in placing the patient's health in serious jeopardy. Record the day, time and name of the person that you spoke to at United Healthcare. Pay by credit card. The bill must be translated into English and the amount of the bill should be converted to American dollars. Submit this claim with a claim form when you return to the states. Non-emergency care provided in the ER is not covered.

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