2018 Schedule of Medical Benefits

Medical Plan Features	Value		HSA	
	For NETWORK providers the plan pays. . .	For NON-NETWORK providers the plan pays. . .	For NETWORK providers the plan pays. . .	For NON-NETWORK providers the plan pays. . .
Care 24 - Call **888-887-4114, Option #2**. A nurse is available to provide immediate medical info and support 24 hrs/day; 100% covered. **Virtual Visits** (on-line doctor visits) - access through the **Health4Me** app on your mobile device or myuhc.com on your computer.				
Preventive Care Routine physical, Immunization, Pap test, Mammogram	100% (deductible and co-payment do not apply)	Not covered	100% (deductible and co-insurance do not apply)	Not covered
Well Baby Care (Preventative)	100% up to 2nd birthday (deductible does not apply)	Not covered	Covered under Preventive Care	Not covered
Chiropractic	$45 copay Limit 12 visits/cal year	50% of MNRP[1] Limit 6 visits/cal year (deductible applies)	80% Limit 12 visits/cal year	60% of MNRP[1] Limit 6 visits/cal year
Physician Services Office Visits	100% after $25 copay/office visit $45 copay/ specialist visit (deductible does not apply)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
Hospital Services Hospital Visits, Inpatient Surgery, Outpatient Surgery, Hospital Newborn Care	80% hospital visits and surgery (deductible applies)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)

Medical Plan Features	Value		HSA	
	For NETWORK providers the plan pays. . .	For NON-NETWORK providers the plan pays. . .	For NETWORK providers the plan pays. . .	For NON-NETWORK providers the plan pays. . .
Health Care Facility Hospital Outpatient (minor surgery, radiation therapy) Hospital Inpatient[2] (room and board, x-rays, intensive care, newborn routine nursery care) Skilled Nursing Facility[2] (room and board up to semi-private room rate, up to 120 days/cal year) Home Health Care[2] (up to 130 visits/cal year) Hospice Care[2] (up to $5,000 max)	80% (deductible applies)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
X-Ray and Lab **Anesthesiology**	80% (deductible applies)	80% when ordered by network provider (deductible applies) 50% of MNRP[1] when ordered by non-network provider (deductible applies)	80% (deductible applies)	80% when ordered by network provider (deductible applies) 60% of MNRP[1] when ordered by non-network provider (deductible applies)
Hospital Emergency Room	80% after $150 copay for emergencies (deductible does not apply) (copayment is not waived even if admitted) 80% after $200 copay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	80% of MNRP[1] after $150 copay for emergencies (deductible does not apply) (copayment is not waived even if admitted) 50% of MNRP[1] after $200 copay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	80% for emergencies (deductible applies) 60% for non-emergencies (deductible applies)	80% of MNRP[1] for emergencies (deductible applies) 60% of MNRP[1] for non-emergencies (deductible applies)

Medical Plan Features	Value		HSA	
	For NETWORK providers the plan pays. . .	For NON-NETWORK providers the plan pays. . .	For NETWORK providers the plan pays. . .	For NON-NETWORK providers the plan pays. . .
Urgent Care Centers	100% after $35 copayment/visit (deductible applies)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
Virtual Doctors	0% copayment/visit (deductible does not apply)	N/A	0% coinsurance after the deductible	N/A
Other Covered Health Services				
Ambulance Service (emergencies)	80% (deductible applies)	80% of MNRP[1] (deductible applies)	80% (deductible applies)	80% of MNRP[1] (deductible applies)
Rehabilitation Therapy: Physical, Speech, Occupational and Respiratory Therapy	80% (deductible applies)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
Bariatric Surgery[2]	80% (deductible applies) (does not count against the out-of-pocket maximum)	50% of MNRP[1] (deductible applies) (does not count against the out-of-pocket maximum)	80% (deductible applies) (does not count against the out-of-pocket maximum)	60% of MNRP[1] (deductible applies) (does not count against the out-of-pocket maximum)
Outpatient Prescription Drugs Tiers as determined by the United HealthCare Prescription Drug List (PDL). See www.myuhc.com for the most current list.	Tier 1 - 90% ($15 min/$25 max) Tier 2 - 80% ($30 min/$55 max) Tier 3 - 60% ($60 min/$85 max) **Mail Order** *90-day supply* Tier 1 - 90% ($25 min/$45 max) Tier 2 - 80% ($60 min/$110 max) Tier 3 - 60% ($120 min/$170 max) (deductible/out-of-pocket maximum do not apply)	Not Covered	Tier 1 - 90% ($15 min/$25 max) Tier 2 - 80% ($30 min/$55 max) Tier 3 - 60% ($60 min/$85 max) **Mail Order** *90-day supply* Tier 1 - 90% ($25 min/$45 max) Tier 2 - 80% ($60 min/$110 max) Tier 3 - 60% ($120 min/$170 max) (deductible/out-of-pocket maximum do not apply)	Not Covered

Medical Plan Features	Value		HSA	
	For NETWORK providers the plan pays. . .	For NON-NETWORK providers the plan pays. . .	For NETWORK providers the plan pays. . .	For NON-NETWORK providers the plan pays. . .
Mental Health and Substance Abuse[3]				
Inpatient Care[3] (maximum apply; see Mental Health and Substance Abuse section)	80% (deductible applies/ out-of-pocket maximums do not apply)	50% of MNRP[1] (deductible applies/ out-of-pocket maximums do not apply)	80% (deductible applies/ out-of-pocket maximums do not apply)	60% of MNRP[1] (deductible applies/ out-of-pocket maximums do not apply)
Outpatient Care[3] (maximum apply; see Mental Health and Substance Abuse section)	80% after $25 copayment (deductible applies/ out-of-pocket maximums do not apply)	50% of MNRP[1] (deductible applies/ out-of-pocket maximums do not apply)	80% (deductible applies/ out-of-pocket maximums do not apply)	60% of MNRP[1] (deductible applies/ out-of-pocket maximums do not apply)
Intermediate Care[3]	80% (deductible applies/ out-of-pocket maximums do not apply)	50% of MNRP[1] (deductible applies/ out-of-pocket maximums do not apply)	80% (deductible applies/ out-of-pocket maximums do not apply)	60% of MNRP[1] (deductible applies/ out-of-pocket maximums do not apply)
Annual Deductible[4]	$825/person; $1,650/family (applies except where specified)	$1,325/person; $2,650/family (applies except where specified)	$1,550 individual plan; $3,100 total for family plan	$3,100 individual plan; $6,200 total for family plan
Out-of-Pocket Maximums[5]	$3,100/person; $6,200/family (except where specified)	$6,200/person; $12,400/family (except where specified)	$4,000/person; $7,350/family	$6,200/person; $12,400/family
Non-Notification Penalty	$200 penalty applies to health facility services requiring pre-notification with UHC; $300 penalty applies to Mental Health/Substance Abuse services requiring UBH pre-notification.			
Maximum Lifetime Benefit	NONE			

[1] Maximum Non-Network Reimbursement Program [2] Pre-notification with UHC is required to receive full plan benefit and avoid penalty. [3] Pre-notification with UBH is required to receive full plan benefits and avoid penalty.

[4]NOTE: Copayments do not apply towards deductible for the Value PPO. [5]The Out-of-Pocket Maximum includes the annual deductible, co-payments, and coinsurance. Go to www.myUHC.com to review your claims, check eligibility of your dependents, order an ID card, locate network providers, and research information on many health topics.

2018 Schedule of Dental Benefits

Plan Feature	Enhanced Dental Plan	Basic Dental Plan
Annual deductible	$25/person	None
Lifetime deductible	None	$50/person
Annual Maximum Benefit	$2,000 (not including orthodontia)	$1,500
Diagnostic/preventive services • Exams • Cleaning (including periodontal) • Application of fluoride • X-rays • Space maintainers	100% of R&C* (deductible does not apply)	80% R&C* after deductible
Basic restorative services • Fillings/extractions • Surgery • Endodontics • Periodontal procedures such as bone and gum (gingival) surgery	80% R&C* after deductible	80% R&C* after deductible
Major restorative services • Onlays • Crowns • Bridges	50% R&C* after deductible	50% R&C* after deductible
Orthodontia & treatment of Bruxism	50% R&C* up to $1,000 lifetime maximum (deductible does not apply)	Not covered
Emergency treatment	Same as any other covered expense	Same as any other covered expense

2018 Schedule of Vision Benefits

Plan Feature	In-Ne-twork	Out-of-Network
Eye exam	Up to $50	Up to $50
Glasses and frames or contacts	Up to $100	Up to $100