

2027 MEDICAL PLAN COMPARISON

Please refer to the official plan documents posted on the Benefits website for additional information on coverage and exclusions.

		UnitedHealthcare Choice Plus Network	
		In-Network Amounts	
		Surest \$0 Deductible	HDHP
Plan Year Deductible			
Individual		\$0	\$3,500
Family		\$0	\$7,000
Plan Year Out-of-Pocket Max <i>(includes deductible, coinsurance, and copays)</i>			
Individual		\$5,000	\$3,500
Family		\$10,000	\$7,000
Pay for Care with Pre-Tax Dollars			
Eligible to fund an HSA		No	Yes
Eligible to fund a healthcare FSA		Yes	No
Preventative Care		\$0	\$0
Office Visits			
		\$20 - \$105	Deductible Only
Primary Care Virtual Visit		\$0	\$0
Specialist Office Visit		\$20 - \$105	Deductible Only
Specialist Virtual Visit		\$0 - \$105	Deductible Only
Routine Diagnostic Test <i>(x-ray, lab, ultrasound)</i>		\$0	Deductible Only
Complex Imaging <i>(MRI, CT, etc.)</i>		\$100 - \$1,400	Deductible Only
Urgent Care		\$60	Deductible Only
Emergency Room		\$650	Deductible Only
Ambulance		\$375	Deductible Only
Maternity			
Prenatal and Postnatal Care		\$0	Deductible Only
Delivery		\$900 - \$2,000	Deductible Only
Inpatient Hospitalization		\$200 - \$3,000	Deductible Only
Procedures (Office, Outpatient, & Inpatient)			
Inpatient and Some Outpatient		\$200 - \$3,000	Deductible Only
Other Outpatient Hospital Services		\$150 - \$850	Deductible Only
Other Inpatient Stay <i>(including admission from ER)</i>		\$2,000	Deductible Only
CVS/CAREMARK	Prescriptions		
	Generic <i>(30 day supply)</i>	\$10	Deductible Only
	Preferred Brand <i>(30 day supply)</i>	20% cost share (\$25 minimum - \$50 maximum copay)	Deductible Only
	Non-Preferred Brand <i>(30 day supply)</i>	50% cost share (\$50 minimum - \$100 maximum copay)	Deductible Only
	Mail Order & Retail <i>(90 day supply)</i>	2x copay amount	Deductible Only
	Specialty <i>(30 day supply)</i>	\$100	Deductible Only

	UnitedHealthcare Choice Plus Network In-Network Amounts	
	Surest \$0 Deductible	HDHP
Mental Health & Substance Use Disorder		
Office Visit	\$15	Deductible Only
Virtual Office Visit	\$15	Deductible Only
Intensive Outpatient Treatment Program	\$60	Deductible Only
Partial Hospitalization Program (Outpatient)	\$110	Deductible Only
Partial Hospitalization Program (Inpatient)	\$1,600	Deductible Only
Rehabilitative Therapies		
Acupuncture ¹	\$25 Copay, In-Network Only	Deductible Only, In-Network Only
Chiropractic ²	\$25 Copay	Deductible Only
Occupational Therapy	\$10 - \$65	Deductible Only
Physical Therapy	\$10 - \$75	Deductible Only
Speech Therapy	\$15 - \$105	Deductible Only
Durable Medical Equipment	\$0 - \$1,000	Deductible Only
Advanced Tests³	\$20 - \$1,300	Deductible Only
Therapeutic Treatments⁴		
Medical Infusions	\$40 - \$2,600	Deductible Only
Chemotherapy	\$25 - \$650	Deductible Only

¹ Acupuncture Therapy has a 20 visit annual limitation.

² Chiropractic Therapy has a 20 visit annual limitation.

³ Advanced Tests are complex medical tests your doctor may order to learn more about your health; typically planned and scheduled separately. Examples include a facility-based sleep study or tilt table testing.

⁴ Therapeutic Procedures are treatments for complex diseases and health needs that do not involve surgery. Examples include radiation therapy or dialysis.