

SUREST PLAN OVERVIEW

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

		UnitedHealthcare Choice Plus Network Surest Plan	
		In-Network	Out-of-Network
Plan Year Deductible		\$0	\$0
Plan Year Coinsurance Individual/Family		None	None
Plan Year Out-of-Pocket Max Individual/Family <i>(includes deductible, coinsurance, and copays)</i>		\$5,000/\$10,000	\$10,000/\$20,000
Preventative Care		\$0	\$160
Office Visits			
Office Visit <i>(Primary Care, Specialist)</i>		\$20 - \$105	\$220
Primary & Urgent Care Virtual Visit		\$0	Not Covered
Specialist Virtual Visit		\$0 - \$105	Not Covered
Teladoc		\$0	Not Covered
Routine Diagnostic Test <i>(x-ray, lab, ultrasound)</i>		\$0	\$0
Complex Imaging <i>(MRI, CT, etc.)</i>		\$100 to \$1,400	Up to \$2,400
Emergency Room		\$650	\$650
Urgent Care		\$60	\$60
Observation Stay		\$650	\$650
Ambulance		\$375	\$375
Procedures <i>(Office, Outpatient, & Inpatient)</i>		\$35 - \$3,000	Up to \$9,000
Procedures <i>(Inpatient and some outpatient)</i>		\$200 - \$3,000	Up to \$9,000
Other Outpatient Hospital Services		\$150 - \$850	\$2,550
Other Inpatient Stay <i>(including admission from ER)</i>		\$2,000	\$6,000
CVS/CAREMARK	Prescriptions		
	Generic <i>(30 day supply)</i>	\$10	In-Network + 50% of remaining cost
	Preferred Brand <i>(30 day supply)</i>	20% cost share (\$25 minimum - \$50 maximum copay)	In-Network + 50% of remaining cost
	Non-Preferred Brand <i>(30 day supply)</i>	50% cost share (\$50 minimum - \$100 maximum copay)	In-Network + 50% of remaining cost
	Mail Order & Retail <i>(90 day supply)</i>	2x copay amount	In-Network + 50% of remaining cost
	Specialty <i>(30 day supply)</i>	\$100	In-Network + 50% of remaining cost
Mental Health & Substance Use Disorder			
Office Visit		\$15	\$160
Virtual Office Visit		\$15	Not Covered
Intensive Outpatient Treatment Program		\$60	\$180
Partial Hospitalization Program		\$110	\$330
In an Outpatient Setting		\$110	\$330
In an Inpatient Setting		\$1,600	\$4,800

UnitedHealthcare Choice Plus Network Surest Plan		
	In-Network	Out-of-Network
Maternity		
Prenatal and Postnatal Care	\$0	\$160
Delivery	\$900 - \$2,000	\$6,000
Home Health Care¹	\$60	\$180
Rehabilitative Therapies	\$10 - \$140	Up to \$240
Acupuncture ²	\$25	<i>Not Covered</i>
Chiropractic ³	\$25	\$75
Occupational Therapy	\$10 - \$65	\$185
Physical Therapy	\$10 - \$75	\$225
Speech Therapy	\$15 - \$105	\$185
Skilled Nursing Facility	\$1,500	\$4,500
Durable Medical Equipment	\$0 - \$1,000	Up to \$2,000
Hospice		
Home Hospice Visit	\$60	\$180
Inpatient Hospice Care	\$2,000	\$6,000
Advanced Tests⁴	\$20 - \$1,300	Up to \$3,150
Chemotherapy	\$25 - \$650	Up to \$1,950
Medical Infusions	\$40 - \$2,600	Up to \$7,800
Therapeutic Treatments⁵	\$15 - \$2,100	Up to \$6,300

¹ 100 visits per calendar year; combined in- and out-of-network.

² Acupuncture Therapy has a 20 visit annual limitation.

³ Chiropractic Therapy has a 20 visit annual limitation.

⁴ 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.

⁵ Therapeutic Procedures are treatments for complex diseases and health needs that do not involve surgery. Examples include radiation therapy or dialysis.