

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OVERVIEW

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

		UnitedHealthcare Choice Plus Network HDHP Plan	
		In-Network	Out-of-Network
Plan Year Deductible			
Individual		\$3,400	\$6,800
Family		\$6,800	\$13,600
Plan Year Coinsurance		Deductible Only	Deductible, then 40%
Plan Year Out-of-Pocket Max (includes deductible, coinsurance, and copays)			
Individual		\$3,400	\$13,600
Family		\$6,800	\$27,200
Preventative Care		\$0	Deductible, then 40%
Office Visits			
Office Visit		Deductible Only	Deductible, then 40%
Specialist Visit		Deductible Only	Deductible, then 40%
Teladoc		\$0	Not Covered
Routine Diagnostic Test (x-ray, lab, ultrasound)		Deductible Only	Deductible, then 40%
Complex Imaging (MRI, CT, etc.)		Deductible Only	Deductible, then 40%
Emergency Room		Deductible Only	Deductible, then 100%
Urgent Care		Deductible Only	Deductible, then 100%
Observation Stay		Deductible Only	Deductible, then 40%
Ambulance		Deductible Only	Deductible, then 100%
Procedures (Office, Outpatient, & Inpatient)			
Procedures (Inpatient and some outpatient)		Deductible Only	Deductible, then 40%
Other Outpatient Hospital Services		Deductible Only	Deductible, then 40%
Other Inpatient Stay (including admission from ER)		Deductible Only	Deductible, then 40%
CVS/CAREMARK	Prescriptions		
	Generic (30 day supply)	Deductible Only	Deductible, then 40%
	Preferred Brand (30 day supply)	Deductible Only	Deductible, then 40%
	Non-Preferred Brand (30 day supply)	Deductible Only	Deductible, then 40%
	Mail Order & Retail (90 day supply)	Deductible Only	Deductible, then 40%
	Specialty (30 day supply)	Deductible Only	Deductible, then 40%
Mental Health & Substance Use Disorder			
Office Visit	Deductible Only	Deductible, then 40%	
Virtual Office Visit	Deductible Only	Not Covered	
Intensive Outpatient Treatment Program	Deductible Only	Deductible, then 40%	
Partial Hospitalization Program	Deductible Only	Deductible, then 40%	
In an Outpatient Setting	Deductible Only	Deductible, then 40%	
In an Inpatient Setting	Deductible Only	Deductible, then 40%	

	UnitedHealthcare Choice Plus Network HDHP Plan	
	In-Network	Out-of-Network
Maternity		
Prenatal and Postnatal Care	Deductible Only	Deductible, then 40%
Delivery	Deductible Only	Deductible, then 40%
Home Health Care¹	Deductible Only	Deductible, then 40%
Rehabilitative Therapies		
Acupuncture	Deductible Only	<i>Not Covered</i>
Chiropractic	Deductible Only	Deductible, then 40%
Massage Therapy	Deductible Only	<i>Not Covered</i>
Occupational Therapy	Deductible Only	Deductible, then 40%
Physical Therapy	Deductible Only	Deductible, then 40%
Speech Therapy	Deductible Only	Deductible, then 40%
Skilled Nursing Facility¹	Deductible Only	Deductible, then 40%
Durable Medical Equipment	Deductible Only	Deductible, then 40%
Hospice		
Home Hospice Visit	Deductible Only	Deductible, then 40%
Inpatient Hospice Care	Deductible Only	Deductible, then 40%
Advanced Tests²	Deductible Only	Deductible, then 40%
Chemotherapy	Deductible Only	Deductible, then 40%
Medical Infusions	Deductible Only	Deductible, then 40%
Therapeutic Treatments³	Deductible Only	Deductible, then 40%

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

² 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.

³ Therapeutic Procedures are treatments for complex diseases and health needs that do not involve surgery. Examples include radiation therapy or dialysis.

HSA EMPLOYER CONTRIBUTIONS <i>(Deposited equally over 24 pay periods.)</i>		
COVERAGE	AMOUNT	PER PAY PERIOD
Employee Only	\$1,000	\$41.67
Employee + Spouse	\$1,500	\$62.50
Employee + Child	\$1,500	\$62.50
Employee + Children	\$2,000	\$83.33
Employee + Family	\$2,000	\$83.33