United HealthCare Options Plan

Choice Plus Plan

for USF College of Medicine effective January 1, 2010

	Tier 1 USF	UHC In-Network	UHC Out-Of-Network
Plan Features			
■ Physician Services Office Visit Copay	-0-	$10 Copay Per Visit	N/A
■ Specialist Copay	-0-	$20 Copay Per Visit	
■ Plan Coinsurance	100%	80%	80%
■ Emergency Room - Copay Waived If Admitted	100%	$50	$50
■ Individual Deductible	-0-	$250	$500
■ Family Deductible	-0-	$500	$1,000
■ Hospital Confinement Deductible	-0-	N/A	$250
■ Non-Notification Penalty	Reduction to 50%	Reduction to 50%	Reduction to 50%
■ Individual Out-Of-Pocket	-0-	$2,000	$4,000
■ Family Out-Of-Pocket	-0-	$4,000	$8,000
■ Lifetime Maximum	$5 Million	$5 Million	$5 Million
Covered Services			
Physician Office Visits	-0-	$10 Copay Per Visit	80% after Deductible
■ Routine Physical Examinations	-0-		Not Covered
■ Diagnostic Lab/X-Ray	N/A	80% after Deductible	80% after Deductible
■ Well Child Care/Immunizations	-0-		Not Covered
■ Preventive Care	-0-		Not Covered
■ Specialist (Office Visit)	-0-	$20 Copay Per Visit	80% after Deductible
Outpatient Diagnostic Services ■ Diagnostic, X-Ray (MRI, catscan, for example)	100%	80% after Deductible	80% after Deductible
Outpatient Surgery ■ Outpatient Surgical Center	100%	80% after Deductible	80% after Deductible
Outpatient Rehabilitation (In office)			
■ Physical Therapy	-0-	$20 Copay	80% after Deductible
■ Occupational Therapy	-0-	$20 Copay	80% after Deductible
■ Speech Therapy	-0-	$20 Copay	80% after Deductible
■ Spinal Manipulation	-0-	$20 Copay	80% after Deductible
20 Visits Of Each Type Per Yr			
Hospital Care ■ Room And Board ■ Diagnostic Lab/X-Ray ■ Misc. Charges	100%	80% after Deductible	80% after Deductible

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Professional Fees - Inpatient ■ Surgeon/Physicians	100%	80% after Deductible	80% after Deductible
Maternity Care ■ Physician Prenatal And Postnatal Care	100%	80% after Deductible	80% after Deductible
Emergency Care ■ Hospital Emergency Room Care (Copay Waived If Admitted) ■ Ambulance Services	$50 Copay 100%	$50 Copay 100%	$50 Copay 100%
■ **Durable Medical Equipment** $50,000 lifetime max	100%	100%	80% after Deductible
■ **Home Health Care** 40 Visits Per Calendar Yr	100%	100%	80% after Deductible
■ **Hospice Services**	100%	100%	80% after Deductible
■ **Skilled Nursing/Extended Care Facility Svcs** 120 Days Per Calendar Yr	100%	100%	80% after Deductible
■ **Infertility Services** For the diagnosis and treatment of underlying medical condition only. No services for ANY facilitation of pregnancy.	100%	100%	80% after Deductible
■ **Transplant Benefits Through United Resource Networks**	100% Through The Program	100% Through The Program	80% after Deductible
■ **Mental Health/Substance Abuse Inpatient** ■ **Outpatient**	100% - 30 days combined in and out-of network -0- Group -0- 30 visits combined in and out-of-network	80% after Deductible - 30 days combined in and out-of network Individual $20 Copay Group $10 Copay 30 visits combined in and out-of-network	80% - 30 days combined in and out-of-network after medical deductible 80% - 30 days combined in and out-of-network after medical deductible 30 visits combined in and out-of-network
Prescription Drug Services			
Retail Pharmacy ■ Retail Generic ■ Retail Formulary Brand ■ Retail Non Formulary	 $10 Copay $25 Copay $40 Copay	 $10 Copay $25 Copay $40 Copay	 Not Covered Not Covered Not Covered

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Brand			
Mail Order Drugs			
■ Mail Order Generic	$20 Copay	$20 Copay	Not Covered
■ Mail Order Formulary Brand	$50 Copay	$50 Copay	Not Covered
■ Mail Order Non Formulary Brand	$80 Copay	$80 Copay	Not Covered
Network Type	Preferred Network	Preferred Network	Not Covered
Generic Drug Policy	Voluntary	Voluntary	Not Covered
Contraceptives – oral, diaphragms and self-administered injectibles	Covered	Covered	Not Covered

- All plan limits are combined for network and non-network services.
- Deductibles and Out of Pocket limits are separate for in network and out of network and do NOT cross apply.