

United HealthCare Options Plan

Choice Plus Plan

for USF College of Medicine

	Tier 1 USF	UHC In-Network	UHC Out-Of-Network
Plan Features			
<ul style="list-style-type: none"> ■ Physician Services Office Visit Copay ■ Specialist Copay ■ Plan Coinsurance ■ Emergency Room - Copay Waived If Admitted ■ Individual Deductible ■ Family Deductible ■ Hospital Confinement Deductible ■ Non-Notification Penalty ■ Individual Out-Of-Pocket ■ Family Out-Of-Pocket ■ Lifetime Maximum 	<ul style="list-style-type: none"> Copay Waived Copay Waived 100% 100% Deductible Waived Deductible Waived Deductible Waived Reduction to 50% Out of Pocket Waived Out of Pocket Waived \$5 Million 	<ul style="list-style-type: none"> \$10 Copay Per Visit \$20 Copay Per Visit 80% \$50 \$250 \$500 N/A Reduction to 50% \$2,000 \$4,000 \$5 Million 	<ul style="list-style-type: none"> N/A 80% \$50 \$500 \$1000 \$250 Reduction to 50% \$4,000 \$8,000 \$5 Million
Covered Services			
Physician Office Visits <ul style="list-style-type: none"> ■ Routine Physical Examinations ■ Diagnostic Lab & X-Ray ■ Well Child Care/Immunizations ■ Preventive Care ■ Specialist (Office Visits) 	<ul style="list-style-type: none"> Copay Waived 	<ul style="list-style-type: none"> \$10 Copay Per Visit \$20 Copay Per Visit 	<ul style="list-style-type: none"> 80% after Deductible Not Covered 80% after Deductible Not Covered Not Covered 80% after Deductible
Outpatient Diagnostic Services <ul style="list-style-type: none"> ■ Diagnostic, Laboratory And X-Ray 	<ul style="list-style-type: none"> 100% 	<ul style="list-style-type: none"> 80% after Deductible 	<ul style="list-style-type: none"> 80% after Deductible
Outpatient Surgery <ul style="list-style-type: none"> ■ Outpatient Surgical Center 	<ul style="list-style-type: none"> 100% 	<ul style="list-style-type: none"> 80% after Deductible 	<ul style="list-style-type: none"> 80% after Deductible
Outpatient Rehabilitation (In office) <ul style="list-style-type: none"> ■ Physical Therapy ■ Occupational Therapy ■ Speech Therapy ■ Spinal Manipulation 20 Visits Of Each Type Per Year	<ul style="list-style-type: none"> Copay Waived 100% 100% Copay Waived 	<ul style="list-style-type: none"> \$20 Copay \$20 Copay \$20 Copay \$20 Copay 	<ul style="list-style-type: none"> 80% after Deductible 80% after Deductible 80% after Deductible 80% after Deductible

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Hospital Care ■ Room And Board ■ Diagnostic Laboratory And X-Ray ■ Misc. Charges	100%	80% after Deductible	80% after Deductible
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 maximum	100%	100%	80% after Deductible
■ Home Health Care 40 Visits Per Calendar Year	100%	100%	80% after Deductible
■ Hospice Services	100%	100%	80% after Deductible
■ Skilled Nursing/Extended Care Facility Services 120 Days Per Calendar Year	100%	100%	80% after Deductible
■ Infertility Services For The Diagnosis And Treatment Of A Medical Condition (Riders available)	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	100% - 30 days combined in and out-of network	80% after Deductible - 30 days combined in and out-of network	80% - 30 days combined in and out-of-network after medical deductible
■ Outpatient	Individual Copay Waived	Individual \$20 Copay	80% - 30 days combined

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	Group Copay Waived 30 visits combined in and out-of-network	Group \$10 Copay 30 visits combined in and out-of-network	in and out-of-network after medical deductible 30 visits combined in and out-of-network
Prescription Drug Services			
Retail Pharmacy			
■ Retail Generic	\$10 Copay	\$10 Copay	Not Covered
■ Retail Formulary Brand	\$25 Copay	\$25 Copay	Not Covered
■ Retail Non Formulary Brand	\$40 Copay	\$40 Copay	Not Covered
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
<ul style="list-style-type: none"> • 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. 			