

Medical Insurance Plan Summaries

	Plan 1 United Healthcare Choice Plus with an H.S.A.		Plan 2 United Healthcare Nexus ACO \$3500 Plan		Plan 3 United Healthcare Choice Plus \$2500 EPO Plan	
	WHAT YOU PAY IN-NETWORK	WHAT YOU PAY OUT OF NETWORK	WHAT YOU PAY TIER 1	WHAT YOU PAY Tier 2	WHAT YOU PAY IN-NETWORK	WHAT YOU PAY OUT OF NETWORK
DOCTORS						
Primary Care	20% after deductible		\$20 copay	\$40 copay	\$30 copay	
\$0 copay for children under the age of 19	N/A		\$0 no copay	\$0 no copay	\$0 no copay	N/A
Specialist Network	20% after deductible		\$40 copay	\$80 copay	\$60 copay	
Preventive Care	Covered 100%		\$0 no copay	\$0 no copay	\$0 no copay	
HOSPITAL						
In-Patient Hospital	20% after deductible		20% after deductible	40% after deductible	20% after deductible	N/A
Out-Patient Surgery	20% after deductible		20% after deductible	40% after deductible	20% after deductible	
EMERGENCY HEALTH SERVICES						
Emergency Room	20% after deductible	20% after deductible	\$1,250 copay per visit. then ded / coins. Waived if admitted.	\$1,250 copay per visit. then ded / coins. Waived if admitted.	\$1,250 copay per visit. then ded / coins. Waived if admitted.	\$1,250 copay per visit. then ded / coins. Waived if admitted.
Ambulance	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
ADDITIONAL SERVICES						
Pregnancy Office Visits	\$0 no copay		\$0 no copay	\$0 no copay	\$0 no copay	
Child Birth / Delivery Professional Services	20% after deductible		20% after deductible	20% after deductible	20% after deductible	
Outpatient Mental Health or Rehab / Habilitation Services	20% after deductible	N/A	\$20 copay	\$20 copay	\$30 copay	N/A
Inpatient Mental Health or Rehab / Habilitation Services	20% after deductible		20% after deductible	20% after deductible	20% after deductible	
URGENT CARE SERVICES						
Urgent Care Facility	20% after deductible	N/A	\$0 after \$100 copay per visit	\$0 after \$100 copay per visit	\$0 after \$75 copay per visit	N/A
LAB & X-RAY SERVICES						
Minor lab & x-ray	20% after deductible		20% after deductible	40% after deductible	20% after deductible	
Major lab & x-ray (MRI, CT Scan, PET Scan)	20% after deductible	N/A	20% after deductible	40% after deductible	20% after deductible	N/A
CALENDAR YEAR DEDUCTIBLE						
INDIVIDUAL	\$4,000	N/A	\$3,500	\$3,500	\$2,500	N/A
FAMILY	\$8,000		\$10,500	\$10,500	\$5,000	
MAXIMUM OUT OF POCKET						
INDIVIDUAL	\$7,000 **		\$7,900 **	\$7,900 **	\$7,500 **	N/A
FAMILY	\$14,000 **		\$15,800 **	\$15,800 **	\$15,000 **	
LIFETIME MAXIMUM BENEFIT						
	Unlimited	N/A	Unlimited	Unlimited	Unlimited	Unlimited

** Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum