

Carrier	United HealthCare			
Plan Name	PPO Modified Select Plus - 80/60		PPO Modified Select Plus - 70/50	
General Plan Information	PPO Providers	Non-Network Providers	PPO Providers	Non-Network Providers
Annual Deductible - Single/Family	\$1,000/\$2,000		\$1,500/\$2,500	\$2,500/\$4,500
Coinsurance	80%	60%	70%	50%
Office Visit PCP/Specialist	\$30 /\$30 copay	40% after deductible	\$25 / \$25 copay	50% after deductible
Annual OOP - Individual/Family	\$4,000/\$8,000	\$7,000/\$14,000	\$5,000/\$10,000	\$12,000/\$25,000
Outpatient Services				
Well-Child Care	No charge	40% after deductible	No charge	Not Covered
Adult Periodic Exam with Preventive Tests	No charge	40% after deductible	No charge	Not Covered
Pregnancy & Maternity Care (Pre-Natal Care)	No charge	40% after deductible	No charge	50% after deductible
Diagnostic X-ray and Lab	No charge	Lab- Not Covered, X-Ray- 40% after deductible	No charge	Lab- Not available X-Ray 50% after deductible
Outpatient Rehab Therapy Services	\$30 copay	Not Covered for physical therapy, occupational therapy, and manipulative treatments. 40% after deductible for all other therapies	\$25 copay	Not Covered for physical therapy, occupational therapy, and manipulative treatments. 50% after deductible for all other therapies
Outpatient Surgery	20% after deductible	40% after deductible, OON- Limits apply	30% after deductible	50% after deductible, OON- Limits apply
Inpatient Hospital Services				
Semi-Private Room & Board; including services & supplies	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Emergency Services				
Emergency Room	\$250 copay per visit	\$250 copay per visit	\$250 copay (waived if admitted)	\$250 copay (waived if admitted)
Urgent Care	\$30 copay	40% after deductible	\$125 copay	50% after deductible
Mental Health & Substance Abuse Benefits				
Inpatient Care	20% after deductible	40% after deductible	30% after deductible	50% after deductible
Outpatient Care	\$30 copay	40% after deductible	\$25 copay	50% after deductible
Prescription Drug Benefits				
Generic	\$10 copay	\$10 copay	\$7 copay	\$7 copay
Brand (Formulary/Preferred)	\$30 copay	\$30 copay	\$20 copay	\$20 copay
Brand (Non-Formulary/Non-Preferred)	\$60 copay	\$60 copay	\$35 copay	\$35 copay
Specialty	Matches Retail In-Network	In-Network Only	Matches Retail In-Network	In-Network Only
Number of Days Supply	31 days	31 days	31 days	31 days
Mail Order				
Generic	\$20 copay	\$20 copay	\$0 copay	\$0 copay
Brand (Formulary/Preferred)	\$60 copay	\$60 copay	\$40 copay	\$40 copay
Brand (Non-Formulary/Non-Preferred)	\$120 copay	\$120 copay	\$70 copay	\$70 copay
Number of Days Supply for Mail Order	90 days	90 days	90 days	90 days
Other Services and Supplies				
Durable Medical Equipment	20% after deductible	Not available	30% after deductible	Not available
Home Health Care	20% after deductible	40%, up to \$150 per visit after deductible	30% after deductible	50%, up to \$150 per visit after deductible
Chiropractic	\$25 copay up to 24 visits	Not Covered	\$25 copay up to 24 visits	Not available
Acupuncture Services	\$25 copay, benefit is 12 visits combined in and out of network	\$25 copay, benefit is 12 visits combined in and out of network	\$25 copay, benefit is 12 visits combined in and out of network	\$25 copay, benefit is 12 visits combined in and out of network
Premium Rates - Monthly				
Employee Only	\$2,193.83		\$2,224.48	
Employee + One	\$4,385.39		\$4,448.95	
Employee + Two or More	\$5,701.20		\$5,784.58	