

ORNL COMPARISON OF MEDICAL PLANS FOR 2016 UHC CONSUMER CHOICE with HSA and PRIME SELECT

This comparison is intended as a guide to highlight differences between the medical plans. For additional information, consult the applicable plan documents, which in all cases are the final authority.

COVERED SERVICES	CONSUMER CHOICE with HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with HSA OUT-OF-NETWORK	PRIME SELECT OUT-OF-NETWORK
PLAN DESIGN FEATURES				
Annual Deductible	Individual coverage: \$1,500 All other coverage levels:\$3,000 <i>(Includes Medical & Rx)</i>	None	Individual coverage: \$2,500 All other coverage levels:\$5,000 <i>(Includes Medical & Rx)</i>	\$200 per individual \$400 per family <i>(Medical only)</i>
<p>Coinsurance is the portion of covered health care costs for which an insured person has a financial responsibility, usually according to a fixed percentage. For example, 90%/10% plan coinsurance means the plan pays 90% of your covered costs (such as costs for physician and surgeon services in a hospital) and you are responsible for paying the remaining 10% after you meet the deductible. Coinsurance amounts apply to your out-of-pocket maximum.</p>				
Out-of-Pocket Annual Maximum <i>(Includes Plan Deductible)</i>	Individual coverage: \$2,500 All other coverage levels \$5,000 <i>(Includes Medical & Rx)</i>	Individual : \$6,850 All other coverage levels: \$13,700 <i>(Includes Medical & Rx)</i>	Individual coverage: \$5,000 All other coverage levels: \$10,000 <i>(Includes Medical & Rx)</i>	Unlimited
<p>The Out of Pocket maximum is the most you will pay during the calendar year, based on your coverage level. Once you meet the maximum, the plan pays 100% of your covered costs. Plan deductibles, copayments ,and coinsurance contribute towards your out of pocket maximum. In-network and out-of-network amounts are separate and do not cross accumulate.</p>				
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Pre-Existing Condition Exclusion Period	N/A	N/A	N/A	N/A
Primary Care Physician (PCP)	Not Required	Not Required	N/A	N/A
PCP Referral	Not Required	Not Required	N/A	N/A
Provider Network	UHC National Network	UHC National Network	N/A	N/A

This summary describes only certain highlights of the company's medical plans.
 *MRC – Medicare based Maximum Reimbursable Charge in your geographic area for similar services

COVERED SERVICES	CONSUMER CHOICE with HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with HSA OUT-OF-NETWORK*	PRIME SELECT OUT-OF-NETWORK*
PHYSICIAN SERVICES				
Office Visit <ul style="list-style-type: none"> Primary Care Physician Specialist 	You pay 10% Plan pays 90% after the plan deductible is met	<ul style="list-style-type: none"> You pay \$20 per visit You pay \$35 per visit 	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Surgery (in a physician's office)	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100% after office visit copay: PCP: \$20 per visit Specialist: \$35 per visit	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Allergy Treatment/Injections Allergy Serum (dispensed by the physician in the office)	You pay 10% Plan pays 90% after the plan deductible is met	No charge for injections. Copay applies for office services Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
PREVENTIVE CARE				
<ul style="list-style-type: none"> Preventive Care: Includes well-baby, well-child, well-woman, and adult preventive care. Includes routine immunizations 	Plan pays 100%	Plan pays 100%	Not covered	Not covered
Mammogram, PSA, Pap Smear and Maternity Screening	Plan pays 100%	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met

COVERED SERVICES	CONSUMER CHOICE with HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with HSA OUT-OF-NETWORK*	PRIME SELECT OUT-OF-NETWORK*
INPATIENT HOSPITAL SERVICES				
Inpatient Services: - Operating room; pharmacy, x-ray and laboratory services; semi-private room and board	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100% after \$250 copay per admission	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
<i>Hospital stays not deemed medically necessary will be disapproved.</i>			<i>You must have all out-of-network inpatient hospitalizations and outpatient surgeries pre-certified through UHC. Failure to do so will result in denied claims.</i>	
Physician and Surgeon Services in Hospital	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
OUTPATIENT SERVICES				
Outpatient surgery • Outpatient Facility	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
			<i>All out-of-network outpatient surgeries must be pre-certified through UHC. Failure to do so will result in denied claims.</i>	
Outpatient Professional Services For services performed by surgeons, radiologists, pathologists and anesthesiologists	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Short-term rehabilitation – Outpatient Includes physical, speech, occupational, cognitive, pulmonary, and cardiac therapy	You pay 10% Plan pays 90% after the plan deductible is met <i>180 days per calendar year for all conditions</i>	Plan pays 100% after copay: PCP: \$20 per visit Specialist: \$35 per visit <i>20 days per calendar year for all conditions</i>	You pay 30% Plan pays 70% after the plan deductible is met <i>180 days per calendar year for all conditions</i>	You pay 20% Plan pays 80% after the plan deductible is met <i>20 days per calendar year for all conditions</i>
<i>Day limits apply to both in- and out-of-network visits Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum.</i>				
Chiropractic Care <i>When medically appropriate</i> -Limited to 25 days per calendar year	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100% after copay: PCP:\$20 per visit Specialist: \$35 per visit	Not Covered	Not Covered

COVERED SERVICES	CONSUMER CHOICE with HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with HSA OUT-OF-NETWORK*	PRIME SELECT OUT-OF-NETWORK*
LAB AND X-RAY				
Outpatient Laboratory and Radiology Services received from: - Outpatient hospital facility - Independent facility - Doctor's office - Advanced Radiology Services such as MRI, PET, MRA, CAT – must be pre-certified and pre-authorized	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
EMERGENCY AND URGENT CARE SERVICES				
Emergency Room Services -Includes radiology, pathology, and physician charges	You pay 10% Plan pays 90% after the plan deductible is met	You pay a \$75 copay, then Plan pays 100% <i>Copay waived if admitted, then inpatient hospital charges would apply</i>	You pay 10% Plan pays 90% after the plan deductible is met <i>Out-of-network services are covered at the in-network rate</i>	You pay a \$75 copay, then Plan pays 100% <i>Out-of-network services are covered at the in-network rate</i>
Ambulance Services <i>Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered</i>	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 10% Plan pays 90% after the plan deductible is met <i>Out-of-network services are covered at the in-network rate</i>	Plan pays 100% <i>Out-of-network services are covered at the in-network rate</i>
Urgent Care Facility <i>Out-of-network services are covered at the in-network rate</i>	You pay 10% Plan pays 90% after the plan deductible is met	You pay a \$25 copay, then Plan pays 100%	You pay 10% Plan pays 90% after the plan deductible is met	You pay a \$25 copay, then Plan pays 100%
Convenience Care	You pay 10% Plan pays 90% after the plan deductible is met	You pay a \$20 copay, then Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met

COVERED SERVICES	CONSUMER CHOICE with HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with HSA OUT-OF-NETWORK*	PRIME SELECT OUT-OF-NETWORK*
OTHER HEALTH CARE SERVICES				
Maternity Care Services Covers maternity for employee and all dependents <ul style="list-style-type: none"> Initial visit to confirm pregnancy All subsequent routine prenatal visits, postnatal visits and delivery Delivery (Inpatient Hospital, Birthing Center) 	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100% after copay for initial visit: PCP: You pay \$20 Specialist: You pay \$35 Delivery: \$250 copay per admission, then Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Infertility Treatment: - Physician office visit, test, counseling - Surgical Treatment: Includes procedures for correction of infertility (in vitro fertilization, artificial insemination, GIFT, ZIFT, etc.)	You pay 10% Plan pays 90% after the deductible is met <i>\$20,000 lifetime maximum In and out of network combined. Lifetime maximum does not apply to diagnostic and planning services.</i>	Not Covered	You pay 30% Plan pays 70% after the plan deductible is met <i>\$20,000 lifetime maximum In and out of network combined. Lifetime maximum does not apply to diagnostic and planning services.</i>	Not Covered
Durable Medical Equipment -Unlimited calendar year maximum	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met

COVERED SERVICES	CONSUMER CHOICE with HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with HSA OUT-OF-NETWORK*	PRIME SELECT OUT-OF-NETWORK*
<p>External Prosthetic Appliances (EPA) Unlimited calendar year maximum <i>Requires approval by Health Plan; limited coverage applies</i></p>	<p>You pay 10% Plan pays 90% after the plan deductible is met</p>	<p>Plan pays 100% after the EPA annual deductible is met</p> <p>An additional \$200 calendar year EPA annual deductible is applied in addition to regular calendar year plan deductible to both in-network and out-of-network services</p>	<p>You pay 30% Plan pays 70% after the plan deductible is met</p>	<p>You pay 20% Plan pays 80% after the EPA annual and the plan deductibles are met</p>
<p><i>Coverage is limited to the most appropriate and cost-effective alternative as determined by the utilization review physician. Covers initial purchase and fitting of any physician-ordered or –prescribed external prosthetic devices that are to be used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of sickness, injury, or congenital defects.</i></p>				
Hearing Aid Benefits	<p>You pay 10% Plan pays 90% after the plan deductible is met \$750 maximum per 36 consecutive months no maximum for children up to age 18</p>	Not Covered	Not Covered	Not Covered

COVERED SERVICES	CONSUMER CHOICE with HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with HSA OUT-OF-NETWORK*	PRIME SELECT OUT-OF-NETWORK*
<p>Temporomandibular Joint Disorder (TMJ) (surgical & non-surgical treatment)</p> <p>Excludes appliances and orthodontic treatment. Subject to medical necessity</p> <p>1. Physician's Office visit 2. Inpatient Facility 3. Outpatient Facility 4. Physician's Services</p>	<p>You pay 10% Plan pays 90% after the plan deductible is met</p>	<p>1. Plan pays 100% after copay for visit: PCP: \$20 Specialist: \$35</p> <p>2. Plan pays 100% after \$250 copay per admission</p> <p>3. Plan pays 100%</p> <p>4. Plan pays 100%</p>	<p>You pay 30% Plan pays 70% after the plan deductible is met</p>	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>
<p>Bariatric Surgery (Subject to medical necessity & clinical guidelines)</p>	<p>You pay 10% Plan pays 90% after the plan deductible is met</p>	<p>PCP: You pay \$20 per visit Specialist: You pay \$35 per visit</p> <p>Inpatient facility: \$250 copay per admission, then plan pays 100%</p> <p>Outpatient: Plan pays 100%</p>	<p>You pay 30% Plan pays 70% after the plan deductible is met</p>	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>
<p><i>Neither the Prime Select nor the Consumers Choice plan will cover non-cancerous skin tag removal. Both plans will cover rhinoplasty, breast reductions, varicose veins and blepharoplasty surgery (removal of excessive eyelid tissue) if medically necessary. Authorization is required.</i></p>				
<p>Myuhc.com, Healthy Pregnancy Program, 24 Hour Nurse Line, (Advocate4me.com)</p>	<p>Yes</p>	<p>Yes</p>	<p>N/A</p>	<p>N/A</p>
<p>MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES</p>				
<p>Inpatient Mental Health UHC Behavioral Health Network -Unlimited days per calendar year</p>	<p>You pay 10% Plan pays 90% after the plan deductible is met</p>	<p>\$250 copay per admission, then Plan pays 100%</p>	<p>You pay 30% Plan pays 70% after the plan deductible is met</p>	<p>You pay 20% Plan pays 80% after the plan deductible is met</p>

COVERED SERVICES	CONSUMER CHOICE with HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with HSA OUT-OF-NETWORK*	PRIME SELECT OUT-OF-NETWORK*
Outpatient Mental Health -Unlimited visits per calendar year -This includes individual, group therapy mental health and intensive outpatient mental health	You pay 10% Plan pays 90% after the plan deductible is met	Primary care physician You pay \$20 per visit Specialist You pay \$35 per visit	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Inpatient Substance Abuse -Unlimited days per calendar year	You pay 10% Plan pays 90% after the plan deductible is met	\$250 copay per admission, then Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Outpatient Substance Abuse -Unlimited visits per calendar year -This includes individual and intensive outpatient substance abuse treatment	You pay 10% Plan pays 90% after the plan deductible is met	Primary care physician You pay \$20 per visit Specialist You pay \$35 per visit	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
OTHER HEALTH CARE FACILITIES				
Home Health Care Skilled visits only	You pay 10% Plan pays 90% after the plan deductible is met Unlimited days per calendar year, in-network	Plan pays 100% 60 days per calendar year in- and out-of-network combined	You pay 30% Plan pays 70% after the plan deductible is met 60 days per calendar year reduced by any in-network days	You pay 20% Plan pays 80% after the plan deductible is met 60 days per calendar year in- and out-of-network combined
Skilled Nursing Facility <i>60 days per calendar year, in and out of network combined</i>	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% after the plan deductible is met
Hospice Care: - Inpatient - Outpatient	You pay 10% Plan pays 90% after the plan deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met	You pay 20% Plan pays 80% After the plan deductible is met

COVERED SERVICES	CONSUMER CHOICE with HSA & PRIME SELECT IN-NETWORK	CONSUMER CHOICE with HSA & PRIME SELECT OUT-OF-NETWORK
VISION PLAN- Services Provided by VSP through the VSP Choice Network		
Adult Vision Services – Age 19 and older	No charge for yearly exam No charge for lenses every 12 months : single vision, bifocal, trifocal or polycarbonate (for dependent children) Frames allowance of up to \$120 plus 20% off excess of \$120 every 24 months; OR Contact lens every 12 months covered up to \$120; allowance applies to cost of contacts and contact lens exam plus 15% off cost of contact exam.	Allowance of up to: Exam \$45.00 Single Vision \$30.00 Bifocals \$50.00 Trifocals \$65.00 Frame \$70.00 OR Elective Contacts \$105.00
Lens options	20% - 25% discount on lens enhancements and upgrades	
Additional Discounts	20% discount on additional prescription glasses and sunglasses. Laser vision correction services at reduced cost through VSP network doctors and contracted laser surgery centers.	
Child Benefit -Up to age 19	The plan provides a covered-in-full annual eye exam, lenses and child’s frame through the VSP Otis & Piper™ frames every 12 months. Patients have the option of providing their own frame, or purchasing a non-Otis & Piper frame from their VSP doctor at 20% off. If patients choose this option, their frame will not be covered by the program. However, their lenses will still be covered. Polycarbonate lenses, scratch-resistant coating, UV protection and rimless mounting are covered in full. OR Elective contact lens services and materials are covered in full, based on the following: Prescription contact lenses are covered up to a minimum three-month supply for the following modalities: <ul style="list-style-type: none"> • Standard (one pair annually) = 1 contact lens per eye (total 2 lenses) • Monthly (six-month supply) = 6 lenses per eye (total 12 lenses) • Bi-weekly (three-month supply) = 6 lenses per eye (total 12 lenses) • Dailies (three-month supply) = 90 lenses per eye (total 180 lenses) 	50% of the provider’s billed amount

COVERED SERVICES	CONSUMER CHOICE with HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with HSA OUT-OF-NETWORK	PRIME SELECT OUT-OF-NETWORK
PRESCRIPTION DRUGS – provided by EXPRESS SCRIPTS				
Retail Prescription Drugs <i>Up to a 30-day supply</i>	<p>Member pays 100% until meets overall plan deductible of \$1500 individual / \$3000 all other coverage levels</p> <p>Then 20% coinsurance</p> <p>Generic: 20% (minimum \$10 / maximum \$75) after deductible</p> <p>Preferred Brand: 20% (minimum \$25 / maximum \$150) after deductible</p> <p>Non-Preferred Brand: 20% (minimum \$40/ maximum \$250) after deductible</p> <p>If actual cost is under the minimum, you pay actual cost</p>	<p>Generic: \$5 co-pay</p> <p>Preferred Brand: 30% coinsurance (minimum \$20 / maximum \$100)</p> <p>Non-preferred Brand: 30% coinsurance (minimum \$40 / maximum \$200)</p> <p>If actual cost is under the minimum, you pay actual cost</p>	50% after plan deductible is met	80% after \$200 pharmacy deductible
Mail Order– Home Delivery <i>Up to a 90-day supply</i>	<p>Member pays 100% until meets overall plan deductible of \$1500 individual / \$3000 all other coverage levels</p> <p>Then 20% coinsurance</p> <p>Generic: 20% (minimum \$20 / maximum \$150) after deductible</p> <p>Preferred Brand: 20% (minimum \$60/ maximum \$300) after deductible</p> <p>Non-Preferred Brand: 20% (minimum \$100/ maximum \$500) after deductible</p> <p>If actual cost is under the minimum, you pay actual cost</p>	<p>Generic: \$12 co-pay</p> <p>Preferred Brand: 30% coinsurance (minimum \$50 / maximum \$200)</p> <p>Non-preferred Brand: 30% coinsurance (minimum \$100 / maximum \$400)</p> <p>If actual cost is under the minimum, you pay actual cost</p>	Not covered	Not covered

Note 1: Certain drugs may require a prior authorization in order to receive the prescription or the full quantity your doctor prescribes. Some medications may have a quantity limit. For a listing of the brand names or categories that currently require prior authorization, see the Prior Authorization List

Note 2: Certain contraceptive items identified by the Plan as preventive care are covered in full and are not subject to copayments or coinsurance.

EXAMPLES OF PRESCRIPTION DRUG COSTS		
CONSUMER CHOICE with HSA: Retail Brand Preferred Coinsurance Examples		
DRUG COST	20% COINSURANCE	MEMBER PAYS
\$60	\$12	\$25 (minimum payment)
\$150	\$30	\$30 (20% of covered cost)
\$800	\$160	\$150 (maximum payment)
PRIME SELECT: Retail Brand Preferred Coinsurance Examples		
DRUG COST	30% COINSURANCE	MEMBER PAYS
\$60	\$18	\$20 (minimum payment)
\$150	\$45	\$45 (30% of covered cost)
\$400	\$120	\$100 (maximum payment)

Retail Refill Allowance: After 3 fills of maintenance drugs at retail, you will pay full cost. Use the mail order program to avoid paying the full cost.
Generic vs. Brand: If you purchase a brand-name medication when a generic is available, you will pay the generic copay/coinsurance, plus the difference in cost between the brand and the generic.

Important Note:

This information describes only certain highlights of the company's medical plans. It does not supersede the actual provisions of the applicable plan documents, which in all cases are the final authority. Company plans, programs, practices or processes may be amended, changed, or terminated by the company at any time without prior notice to, or consent by, participants. This notice does not constitute a contract of employment between the company and any individual, or an obligation by the company to maintain any particular benefit program, practice or policy.