2023 BENEFITS

MEDICAL PLAN COMPARISON FOR UNDER AGE 65 RETIREES: UHC CONSUMER CHOICE and PRIME SELECT

OAK RIDGE National Laboratory

This comparison is intended as a guide to highlight the differences between the medical plans. For additional information and exclusions, please refer to the Summary Plan Description.

PLAN DESIGN FEATURES	CONSUMER CHOICE with an HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with an HSA OUT-OF-NETWORK	PRIME SELECT OUT-OF-NETWORK
Annual Deductible *The amount of money that you must pay before UHC will pay a claim*	Employee only: $1,500 All other coverage levels: $3,000 *(Includes Medical & Rx)*	Not required (except for additional $200 deductible required for external prosthetic appliances)	Employee only: $2,500 All other coverage levels: $5,000 *(Includes Medical & Rx)*	Employee only: $200 All other coverage levels: $400 *(Medical only)*
Coinsurance and Copays *Coinsurance is the percentage you pay after you have met your deductible for covered services until you meet the out-of-pocket maximum; copay is a set amount you pay for a designated service*	You pay 10% for medical services and plan pays 90% after the deductible is met See chart on page 10 for prescription drugs	You pay a $20 or $35 copay for most medical services; specific copays are highlighted in this document See chart on page 10 for prescription drugs	You pay 30% for medical services after the deductible is met See chart on page 10 for prescription drugs	You pay 20% for medical services after the deductible is met See chart on page 10 for prescription drugs
Out-of-Pocket Annual Maximum *Deductibles, copayments, and coinsurance contribute toward your out-of-pocket maximum; in-network and out-of-network amounts are separate and do not cross-accumulate*	Employee only: $2,500 All other coverage levels: $5,000 *(Includes Medical & Rx)* After maximum is met, Plan pays 100% of your covered costs	Employee only: $9,100 All other coverage levels: $18,200 *(Includes Medical & Rx)* After maximum is met, Plan pays 100% of your covered costs	Employee only: $5,000 All other coverage levels: $10,000 *(Includes Medical & Rx)* After maximum is met, Plan pays 100% of your covered costs	Unlimited

COVERED SERVICES	CONSUMER CHOICE with an HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with an HSA OUT-OF-NETWORK	PRIME SELECT OUT-OF-NETWORK
PREVENTIVE CARE				
Includes well-baby, well-child, well-woman, adult preventive care, and routine immunizations	Plan pays 100%	Plan pays 100%	Not covered	Not covered
Mammogram, pap smear, and maternity screening	Plan pays 100%	Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
PHYSICIAN SERVICES				
Office Visit *Primary care physician (PCP) or specialist*[1]	You pay 10% Plan pays 90% after the deductible is met	You pay $20 per PCP visit or $35 per specialist visit, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
Surgery *In a physician's office*	You pay 10% Plan pays 90% after the deductible is met	You pay $20 per PCP visit or $35 per specialist visit, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
Allergy treatment/injections **Allergy serum** *Dispensed by the physician in the office*	You pay 10% Plan pays 90% after the deductible is met	No charge for injections; copay applies for office services Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met

1. COVID-19 testing incurred during the National Emergency will be covered at 100%.

COVERED SERVICES	CONSUMER CHOICE with an HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with an 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 receive prior authorization	You pay 10% Plan pays 90% after the deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met Prior authorization is required; otherwise 20% penalty applies	You pay 20% Plan pays 80% after the deductible is met Prior authorization is required; otherwise 20% penalty applies
EMERGENCY AND URGENT CARE SERVICES *Emergency room services are covered for the treatment of a serious medical condition or symptom (including severe pain) resulting from injury, sickness, or mental illness that arises suddenly and requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to the life or health of the member.*				
Emergency room services *Includes radiology, pathology, and physician charges* *Out-of-network services are covered at the in-network rate*	You pay 10% Plan pays 90% after the deductible is met	You pay a $75 copay, then Plan pays 100% *Copay waived if admitted, then inpatient hospital charges would apply*	You pay 10% Plan pays 90% after the in-network deductible is met (MRC does not apply)	You pay a $75 copay, then Plan pays 100% (MRC does not apply)
Ambulance services ground and air transport *Out-of-network services are covered at the in-network rate; nonemergency transportation requires prior authorization*	You pay 10% Plan pays 90% after the deductible is met	Plan pays 100%	You pay 10% Plan pays 90% after the in-network deductible is met (MRC does not apply)	Plan pays 100% (MRC does not apply)
Urgent care facility *Out-of-network services are covered at the in-network rate*	You pay 10% Plan pays 90% after the deductible is met	You pay a $25 copay, then Plan pays 100%	You pay 10% Plan pays 90% after the in-network deductible is met (MRC does not apply)	You pay a $25 copay, then Plan pays 100% (MRC does not apply)
Convenience care	You pay 10% Plan pays 90% after the deductible is met	You pay a $20 copay, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
Virtual visits	You pay 10% Plan pays 90% after the deductible is met	You pay $20, then Plan pays 100%	Not available	Not available

COVERED SERVICES	CONSUMER CHOICE with an HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with an HSA OUT-OF-NETWORK	PRIME SELECT OUT-OF-NETWORK
OUTPATIENT SERVICES				
Outpatient surgery *Outpatient facility*	You pay 10% Plan pays 90% after the deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
			Out-of-network outpatient surgeries must receive prior authorization through UHC; otherwise a 20% penalty will apply.	
Outpatient professional services *Includes those performed by surgeons, radiologists, pathologists and anesthesiologists*	You pay 10% Plan pays 90% after the deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
Outpatient short-term rehabilitation *Includes physical, speech, occupational, cognitive, pulmonary, and cardiac therapy*	You pay 10% Plan pays 90% after the deductible is met *180 days per calendar year for all conditions*	You pay $20 per PCP visit and $35 per specialist visit, then Plan pays 100% *20 days per calendar year for all conditions*	You pay 30% Plan pays 70% after the deductible is met *180 days per calendar year for all conditions*	You pay 20% Plan pays 80% after the deductible is met *20 days per calendar year for all conditions*
	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.			
Chiropractic care *When medically appropriate; limited to 25 days per calendar year*	You pay 10% Plan pays 90% after the deductible is met	You pay $20 per PCP visit or $35 per specialist visit, then Plan pays 100%	Not covered	Not covered
INPATIENT HOSPITAL SERVICES				
Inpatient facility: Operating room, pharmacy, x-ray and laboratory services; semiprivate room and board *Hospital stays not deemed medically necessary are not covered*	You pay 10% Plan pays 90% after the deductible is met	You pay $250 per admission, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
			Out-of-network inpatient hospitalizations must receive prior authorization through UHC; otherwise a 20% penalty will apply.	
Physician and surgeon services in hospital	You pay 10% Plan pays 90% after the deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met

COVERED SERVICES	CONSUMER CHOICE with an HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with an HSA OUT-OF-NETWORK (Based on MRC*)	PRIME SELECT OUT-OF-NETWORK (Based on MRC*)
OTHER HEALTH CARE SERVICES				
Maternity care services Covers maternity for employee and all covered dependents • Initial visit to confirm pregnancy • All subsequent routine prenatal visits, postnatal visits • Delivery (inpatient hospital, birthing center)	You pay 10% Plan pays 90% after the deductible is met You pay $0 Plan pays 100% (for subsequent routine prenatal visits, postnatal visits) You pay 10% Plan pays 90% after the deductible is met	You pay $20 per PCP visit or $35 per specialist visit, then Plan pays 100% You pay $0 Plan pays 100% (for subsequent routine prenatal visits, postnatal visits) Delivery: $250 copay per admission, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
	Newborns of a covered child dependent are not covered for services rendered after their birth unless they become an eligible covered dependent under the plan.			
Infertility treatment • Physician office visit, test, and 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 *$20,000 lifetime maximum in- and out-of-network combined; lifetime maximum does not apply to diagnostic and planning services*	Not covered	You pay 30% Plan pays 70% after the deductible is met *$20,000 lifetime maximum in-and out-of-network combined; lifetime maximum does not apply to diagnostic and planning services*	Not covered
Durable medical equipment • Unlimited calendar year maximum	You pay 10% Plan pays 90% after the deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
External prosthetic appliances (EPAs) *Unlimited calendar year maximum* *Requires approval by Health Plan; limited coverage applies*	You pay 10% Plan pays 90% after the deductible is met	Plan pays 100% after the $200 EPA annual deductible is met	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the $200 EPA annual and the plan deductibles are met
	Benefits are available for Class III and Class IV prosthetic devices. An evaluation by an orthopedic surgeon or a physical and rehabilitation physician is required, in addition to a prescription, to provide the clinical justification for advanced prosthetic devices and myoelectric limbs.			

COVERED SERVICES	CONSUMER CHOICE with an HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with an HSA OUT-OF-NETWORK	PRIME SELECT OUT-OF-NETWORK
Hearing aid benefits	You pay 10% Plan pays 90% after the deductible is met $750 maximum per 36 consecutive months; no maximum for children up to age 18	Not covered	Not covered	Not covered
Applied behavior analysis *Services for the treatment of autism spectrum disorder by an eligible provider*	You pay 10% Plan pays 90% after the deductible is met	You pay $20 per PCP visit or $35 for specialist visit, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
Organ transplant coverage • Inpatient facility • Travel benefit	Inpatient: Plan pays 100% at Center of Excellence after deductible is met; otherwise Plan pays 90% after deductible is met (if facility is contracted with UHC for transplant services) Physician services: Plan pays 100% at Center of Excellence after deductible is met; otherwise Plan pays 90% after deductible is met Travel maximum: $10,000 per transplant (only available if using Center of Excellence facility)	Inpatient: Plan pays 100% at Center of Excellence; otherwise Plan pays same as Plan's inpatient hospital facility benefit (if facility is contracted with UHC for transplant services) Physician services: Plan pays 100% Travel maximum: $10,000 per transplant (only available if using Center of Excellence facility)	You pay 30% Plan pays 70% after the deductible is met	Not covered

COVERED SERVICES	CONSUMER CHOICE with an HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with an HSA OUT-OF-NETWORK	PRIME SELECT OUT-OF-NETWORK
Accidental dental care Limited to charges for a continuous course of dental treatment started within 6 months of an injury to sound, natural teeth 1. Physician's office visit 2. Inpatient facility 3. Outpatient facility 4. Physician's services	You pay 10% Plan pays 90% after the deductible is met	1. You pay $20 per PCP visit or $35 per specialist visit, then Plan pays 100% 2. You pay a $250 copay per admission, then the Plan pays 100% 3. Plan pays 100% 4. Plan pays 100%	You pay 10% Plan pays 90% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
Temporomandibular Joint Disorder (TMJ) surgical and non-surgical treatment *Excludes appliances and orthodontic treatment; subject to medical necessity* 1. Physician's office visit 2. Inpatient facility 3. Outpatient facility 4. Physician's services	You pay 10% Plan pays 90% after the deductible is met	1. You pay $20 per PCP visit or $35 per specialist visit, then Plan pays 100% 2. You pay a $250 copay per admission, then the Plan pays 100% 3. Plan pays 100% 4. Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
Bariatric Surgery and Gender Dysphoria *Both are subject to medical necessity and clinical guidelines*	You pay 10% Plan pays 90% after the deductible is met	You pay PCP $20 per PCP visit or $35 per specialist visit Inpatient facility: You pay a $250 copay per admission, then plan pays 100% Outpatient: Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
Myuhc.com, Healthy Pregnancy Program, 24-hour nurse line, Advocate4me.com	Available	Available	Available	Available

COVERED SERVICES	CONSUMER CHOICE with an HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with an HSA OUT-OF-NETWORK	PRIME SELECT OUT-OF-NETWORK
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES				
Inpatient mental health UHC Behavioral Health Network *Unlimited days per calendar year*	You pay 10% Plan pays 90% after the deductible is met	You pay $250 copay per admission, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
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 deductible is met	You pay $20 per PCP visit or $35 per specialist visit	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
Inpatient substance abuse *Unlimited days per calendar year*	You pay 10% Plan pays 90% after the deductible is met	You pay $250 copay per admission, then Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the 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 deductible is met	You pay $20 per PCP visit or $35 per specialist visit	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
OTHER HEALTH CARE FACILITIES				
Home health care *Skilled visits only*	You pay 10% Plan pays 90% after the 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 deductible is met 60 days per calendar year reduced by any in-network days	You pay 20% Plan pays 80% after the deductible is met 60 days per calendar year in- and out-of-network combined
Skilled nursing facility *60 days per calendar year in- and out-of-network combined*	You pay 10% Plan pays 90% after the deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% after the deductible is met
Hospice Care *Inpatient and outpatient*	You pay 10% Plan pays 90% after the deductible is met	Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met	You pay 20% Plan pays 80% After the deductible is met

COVERED SERVICES	CONSUMER CHOICE with an HSA & PRIME SELECT IN-NETWORK	CONSUMER CHOICE with an HSA & PRIME SELECT OUT-OF-NETWORK
VISION SERVICES provided through Vision Service Plan (VSP) through VSP Choice Network		
Vision services	No charge for yearly exam No charge for lenses every 12 months: single vision, bifocal, trifocal, or polycarbonate (for dependent children) Frame allowance of up to $120 plus 20% off excess of $120 every 24 months **OR** Contact lenses 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 Single vision $30 Bifocals $50 Trifocals $65 Frame $70 **OR** Elective contacts $105
Lens options	20% to 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	
Necessary contact lenses	Plan pays 100% of professional fees and materials	Professional fees and materials covered up to $210
Low vision benefit *Maximum benefit available is $1,000 every 2 years*	Plan pays 100% Plan pays 75% of supplemental care aids cost	Supplementary testing covered up to $125 Supplemental care aids covered 75% of cost

COVERED SERVICES	CONSUMER CHOICE with an HSA IN-NETWORK	PRIME SELECT IN-NETWORK	CONSUMER CHOICE with an HSA OUT-OF-NETWORK	PRIME SELECT OUT-OF-NETWORK
PRESCRIPTION DRUGS provided through EXPRESS SCRIPTS				
Retail Prescription Drugs *Up to a 30-day supply*	You pay 100% until you meet deductible of $1,500 employee only/$3,000 all other coverage levels; after deductible is met, you pay 20% for generic brands ($10 minimum/$75 maximum) 20% for preferred brands ($25 minimum/$150 maximum) 20% for nonpreferred brands ($40 minimum/$250 maximum) If actual cost is under the minimum, you pay actual cost	You pay $5 for generic brands 30% for preferred brands ($20 minimum/$100 maximum) 30% for nonpreferred brands ($40 minimum/$200 maximum) If actual cost is under the minimum, you pay actual cost	You pay 50% after deductible is met	You pay 80% after $200 pharmacy deductible is met
Mail Order *Home delivery; up to a 90-day supply*	You pay 100% until you meet deductible of $1,500 employee only/ $3,000 all other coverage levels; after deductible is met, you pay 20% for generic brands ($20 minimum/ $150 maximum) 20% for preferred brands ($60 minimum/$300 maximum) 20% for nonpreferred brands ($100 minimum/$500 maximum) 20% for specialty medications ($60 minimum/$300 maximum) If actual cost is under the minimum, you pay actual cost	You pay $12 for generic brands 30% for preferred brands ($50 minimum/$200 maximum) 30% for nonpreferred brands ($100 minimum/$400 maximum) 30% for specialty medications ($50 minimum/$200 maximum) If actual cost is under the minimum, you pay actual cost	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 drugs identified by the ACA as preventive care are covered in full and are not subject to copayments or coinsurance.*

Retail Refill Allowance: *After three fills of maintenance drugs at retail, you will pay the full cost unless you use the mail order program.*
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.*