SECTION 5 - PLAN HIGHLIGHTS

What this section includes:

- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Plan A		Plan B	
	Network	Non-Network	Network	Non-Network
Copays				
■ Emergency Health Services	$89	$89	$61	$61
■ Physician's Office Services	$17	Not Applicable	$11	Not Applicable
■ Urgent Care Center Services	$17	Not Applicable	$11	Not Applicable
■ Virtual Visits	$17	Not Applicable	$11	Not Applicable
In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.				
Copays apply toward the Annual Deductible and Out-of-Pocket Maximum.				

Plan Features	Plan A		Plan B	
	Network	Non-Network	Network	Non-Network
Annual Deductible ■ Individual	$299		No Annual Deductible	$299
■ Family (not to exceed the Individual amount per Covered Person)	$899		No Annual Deductible	$899
Annual Out-of-Pocket Maximum ■ Individual	$898	$2,097	$599	$1,498
■ Family (not to exceed the applicable Individual amount per Covered Person)	$2,697	$6,296	$1,801	$4,497
The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.				
Lifetime Maximum Benefit	Unlimited There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act:* Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.			

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services[1]	Plan A		Plan B	
	Network	Non-Network	Network	Non-Network
Acupuncture Services	Depending upon where the Covered Health Service is provided, Benefits will be paid the same as those stated under each Covered Health Service category in this section.			
Allergy				
■ Allergy Care	100% after you pay a $17 per visit Copay	70% after you meet the Annual Deductible	100% after you pay a $11 per visit Copay	80% after you meet the Annual Deductible
■ Allergy Testing/Treatment	90% after you meet the Annual Deductible At Office: 100% after you pay a $17 per visit Copay	70% after you meet the Annual Deductible	100% At Office: 100% after you pay a $11 per visit Copay	80% after you meet the Annual Deductible
Ambulance Services				
■ Emergency Ambulance	100%	100%	100%	100%
■ Non-Emergency Ambulance	100%	100%	100%	100%
Cancer Services For Network Benefits, oncology services must be received at a Designated Facility. See *Cancer Resource Services (CRS)* in Section 6, *Additional Coverage Details*.	Depending upon where the Covered Health Service is provided, Benefits will be paid the same as those stated under each Covered Health Service category in this section.			

Covered Health Services[1]	Plan A		Plan B	
	Network	Non-Network	Network	Non-Network
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits will be paid the same as those stated under each Covered Health Service category in this section.			
Congenital Heart Disease (CHD) Surgeries	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Dental Services - Accident Only	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Diabetes Services ■ Diabetes Self-Management and Training/ Diabetic Eye Examinations/ Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.			
■ Diabetes Self-Management Items - Diabetes equipment. - Diabetes supplies.	Benefits for diabetes equipment will be the same as those stated under *Durable Medical Equipment* in this section.			
	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Disposable Medical Supplies	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Durable Medical Equipment (DME)	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible

Covered Health Services[1]	Plan A		Plan B	
	Network	Non-Network	Network	Non-Network
Emergency Health Services – Outpatient If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	100% after you pay a $89 per visit Copay	100% after you pay a $89 per visit Copay	100% after you pay a $61 per visit Copay	100% after you pay a $61 per visit Copay
Enteral Nutrition	90% after you meet the Annual Deductible At Office: 100% after you pay a $17 per visit Copay	70% after you meet the Annual Deductible	100% At Office: 100% after you pay a $11 per visit Copay	80% after you meet the Annual Deductible
Home Health Care Up to 100 visits per calendar year	100%	Not Covered	100%	Not Covered
Hospice Care	100%	Not Covered	100%	Not Covered
Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Infertility Services Diagnosis and treatment of underlying medical condition only	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Kidney Services See *Kidney Resource Services (KRS)* in Section 6, *Additional Coverage Details*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.			

Covered Health Services[1]	Plan A		Plan B	
	Network	Non-Network	Network	Non-Network
Lab, X-Ray and Diagnostics - Outpatient	100%	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	100%	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Mental Health Services ■ Inpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
■ Outpatient	100% after you pay a $17 per visit Copay	70% after you meet the Annual Deductible	100% after you pay a $11 per visit Copay	80% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Inpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
■ Outpatient	100% after you pay a $17 per visit Copay	70% after you meet the Annual Deductible	100% after you pay a $11 per visit Copay	80% after you meet the Annual Deductible
Obesity Surgery See Section 6, *Additional Coverage Details*, for limits.	Depending upon where the Covered Health Service is provided, Benefits will be paid the same as those stated under each Covered Health Service category in this section.			

Covered Health Services[1]	Plan A		Plan B	
	Network	Non-Network	Network	Non-Network
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	90% after you meet the Annual Deductible At Office: 100% after you pay a $17 per visit Copay	70% after you meet the Annual Deductible	100% At Office: 100% after you pay a $11 per visit Copay	80% after you meet the Annual Deductible
Ostomy Supplies	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	Office Visit: 100% after you pay a $17 per visit Copay No Copay applies when a Physician Charge is not assessed. Immunizations are paid at 100%	70% after you meet the Annual Deductible	Office Visit: 100% after you pay a $11 per visit Copay No Copay applies when a Physician Charge is not assessed. Immunizations are paid at 100%	80% after you meet the Annual Deductible
Pregnancy – Maternity Services	Depending upon where the Covered Health Service is provided, Benefits will be paid the same as those stated under each Covered Health Service category in this section.			

Covered Health Services[1]	Plan A		Plan B	
	Network	Non-Network	Network	Non-Network
Preventive Care Services				
■ Physician Office Services	100%	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Tests	100%	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
■ Breast pumps	100%	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Private Duty Nursing - Outpatient Up to 70 shifts per calendar year	90% after you meet the Annual Deductible	Not Covered	100%	Not Covered
Prosthetic Devices	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be paid the same as those stated under each Covered Health Service category in this section.			
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible

Covered Health Services[1]	Plan A		Plan B	
	Network	Non-Network	Network	Non-Network
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100%	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 90 days per calendar year	90% after you meet the Annual Deductible	Not Covered	100%	Not Covered
Substance Use Disorder Services				
■ Inpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
■ Outpatient	100% after you pay a $17 per visit Copay	70% after you meet the Annual Deductible	100% after you pay a $11 per visit Copay	80% after you meet the Annual Deductible
Surgery - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible
Temporomandibular Joint (TMJ) Services	Depending upon where the Covered Health Service is provided, Benefits will be paid the same as those stated under each Covered Health Service category in this section.			
Therapeutic Treatments - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100%	80% after you meet the Annual Deductible

Covered Health Services[1]	Plan A		Plan B	
	Network	Non-Network	Network	Non-Network
Transplantation Services Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.	Depending upon where the Covered Health Service is provided, Benefits will be paid the same as those stated under each Covered Health Service category in this section.			
Urgent Care Center Services	100% after you pay a $17 per visit Copay	70% after you meet the Annual Deductible	100% after you pay a $11 per visit Copay	80% after you meet the Annual Deductible
Virtual Visits Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.	100% after you pay a $17 per visit Copay	Not Covered	100% after you pay a $11 per visit Copay	Not Covered
Vision Examinations Up to one exam every other calendar year	100% after you pay a $17 per visit Copay	70% after you meet the Annual Deductible	100% after you pay a $11 per visit Copay	80% after you meet the Annual Deductible
Walk-In Clinics Non-Emergency Visits	100% after you pay a $17 per visit Copay	70% after you meet the Annual Deductible	100% after you pay a $11 per visit Copay	80% after you meet the Annual Deductible

[1]You must notify Care Coordination℠, as described in Section 4, *Care Coordination℠* to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying Care Coordination℠ before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.