Medical

	UnitedHealthcare Medical Copay		UnitedHealthcare Medical HDHP/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual / Family	$2,000 / $4,000	$4,000 / $8,000	$3,200 / $6,000	$6,000 / $12,000
Coinsurance *(after deductible)*	80%	60%	90%	70%
Maximum Out-of-Pocket				
Individual / Family	$5,500 / $11,000	$8,000 / $16,000	$4,000 / $8,000	$10,000 / $20,000
Physician Office Visit			AFTER DEDUCTIBLE	
Primary Care	No Charge	60%	90%	70%
Virtual Visit	No Charge	60%	90%	70%
Specialty Care	$50 copay, Designated Network*. $100 copay, Network*	60%	90%	70%
Preventive Care	No charge	60%	No charge	70%
Diagnostic Services			AFTER DEDUCTIBLE	
Outpatient Radiology and Lab	80%	60%	90%	70%
Urgent Care Facility	$25 copay*	60%	90%	70%
Emergency Room Facility Charges	$250 copay per visit, 20% coinsurance*		90%	90%
Inpatient & Outpatient Facility	80%	60%	90%	70%
Elixir RX Retail Pharmacy (30 Day Supply)			AFTER DEDUCTIBLE	
Generic (Tier 1)	$15 copay	Not covered	90%	Not covered
Preferred (Tier 2)	$50 copay	Not covered	90%	Not covered
Non-Preferred (Tier 3)	$70 copay	Not covered	90%	Not covered
Preferred Specialty (Tier 4)	25% coinsurance	Not covered	90%	Not covered
Elixir RX Mail Order Pharmacy (90 Day Supply)			AFTER DEDUCTIBLE	
Generic (Tier 1)	$30 copay	Not covered	90%	Not covered
Preferred (Tier 2)	$100 copay	Not covered	90%	Not covered
Non-Preferred (Tier 3)	$140 copay	Not covered	90%	Not covered
Preferred Specialty (Tier 4)	25% coinsurance	Not covered	90%	Not covered

*Deductible does not apply