



My Benefits: Health Protection

Medical

Medical coverage is one of the most effective ways to protect yourself and your family while promoting good health through preventive care. Once again, we are offering you medical coverage administered by United Healthcare. This plan meets ACA requirements.

Plan Details



Benefit		In-Network	Out-of-Network
Financial			
Deductible	Single	None	\$750
	Family	None	\$1,500
Coinsurance		None	20%
Maximum Out-of-Pocket (Including Deductible)	Single	\$2,500	\$1,750
	Family	\$5,000	\$3,500
Financial Accumulation Period		Calendar Year	Calendar Year
Out-of-Network Reimbursement		Not Applicable	Very High UCR ¹
Preventive Care			
Adult Preventive Care		No Charge	In-Network Benefit Only
Infant and Pediatric Preventive Care		No Charge	Deductible & 20% Coinsurance
Outpatient Care			
Primary Care Physician Office Visits		\$25 copay per visit	Deductible & 20% Coinsurance
Specialist Office Visits		\$25 copay per visit	Deductible & 20% Coinsurance
Outpatient Facility Surgery **		No Charge	Deductible & 20% Coinsurance
Laboratory Services Participating** (See your Certificate of Coverage for additional Lab details)		No Charge	Deductible & 20% Coinsurance
MRIs, MRAs, PET Scan, CT Scan, Ultrasound**		No Charge	Deductible & 20% Coinsurance
Radiology Services**		No Charge	Deductible & 20% Coinsurance
Hospital Care			
Physician's and Surgeon's Services**		No Charge	Deductible & 20% Coinsurance
Semi-Private Room and Board **		\$250 copay per continuous confinement	Deductible & 20% Coinsurance
All Drugs and Medication		No Charge	Deductible & 20% Coinsurance
Emergency Care			
Ambulance Service when Medically Necessary**		No Charge	No Charge
At Hospital Emergency Room (If member is admitted to the hospital, notification is required)		\$100 copay, waived if admitted	\$100 copay, waived if admitted
Emergency Care in Urgi-Center		\$25 copay per visit	Deductible & 20% Coinsurance
Maternity Care			
Routine Prenatal and Post-Natal Care**		No Charge	Deductible & 20% Coinsurance
Hospital Services for Mother and Child**		\$250 copay per continuous confinement	Deductible & 20% Coinsurance
Skilled Nursing Facility			
30 Days per Calendar Year**		\$250 copay per continuous confinement	Deductible & 20% Coinsurance
Hospice Care (210 days combined per Calendar Year for Inpatient & Home)			
Inpatient Care**		\$250 copay per continuous confinement	Deductible & 20% Coinsurance
Home Hospice Care**		\$25 copay per visit	Subject to 20% Coinsurance
Home Health Care			
Home Care Visits - 60 Visits per Calendar Year**		\$25 copay per visit	Subject to 20% Coinsurance
Physician House Calls**		\$25 copay per visit	Deductible & 20% Coinsurance



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Plan Details (continued)



Benefit	In-Network	Out-Of-Network
Substance Use Disorder Services		
Inpatient Rehabilitation**	\$250 copay per continuous confinement	Deductible & 20% Coinsurance
Outpatient Rehabilitation	\$25 copay per visit	Deductible & 20% Coinsurance
Office Visits	\$25 copay per visit	Deductible & 20% Coinsurance
Mental Health Care		
Inpatient Care**	\$250 copay per continuous confinement	Deductible & 20% Coinsurance
Outpatient Care	\$25 copay per visit	Deductible & 20% Coinsurance
Office Visits	\$25 copay per visit	Deductible & 20% Coinsurance
Allergy Care		
Testing and Treatment**	\$25 copay per visit	Deductible & 20% Coinsurance
Chiropractic Care		
Chiropractic Care**	\$25 copay per visit	Deductible & 20% Coinsurance
Short Term Rehab & Habilitative Services		
Inpatient – Unlimited**	\$250 copay per continuous confinement	Deductible & 20% Coinsurance
Outpatient limited to 90 combined Visits per Calendar Year**	\$25 copay per visit	Deductible & 20% Coinsurance
Durable Medical Equipment		
Unlimited**(Precert required for items over \$500**)	No Charge when ordered by a Participating Physician	Deductible & 20% Coinsurance
Hearing Aids		
Limited to a single purchase (including repair/replacement) every 3 Years.	No Charge	Deductible & 20% Coinsurance
Medical Supplies		
Medical Supplies when Medically Necessary**	Out-of-Network Benefit Only	Deductible & 20% Coinsurance
Exercise Facility		
Subscriber	\$200 reimbursement per 6-month period	\$200 reimbursement per 6-month period
Spouse	\$100 reimbursement per 6-month period	\$100 reimbursement per 6-month period
Advanced Infertility Treatment (\$10,000 per lifetime)		
Specialist Office Visits**	\$25 copay per visit	In-Network Benefit Only
Inpatient Facility Services**	\$250 copay per continuous confinement	In-Network Benefit Only
Outpatient Facility Services**	No Charge	In-Network Benefit Only

**These services require precertification through UMR. Members must call UMR at 1-800-826-9781 or 1-866-494-4502 at least 14 days in advance of treatment to request precertification.

¹The Very High UCR fee schedule contains the maximum allowable fees and is set using data from the FH Benchmarks database, from FAIR Health, Inc., and Centers for Medicare and Medicaid Services (CMS) and sources recognized by the federal government and insurance industry as a basis for evaluating and establishing fees. The fee schedule for physician-administered pharmaceutical products is based upon a percentage of Average Wholesale Price. If a data source is no longer available, we will use a comparable data source to establish fees. Additional information about how we set the UCR fee schedule and reimburse Out-of-Network Covered Services is available in the Certificate of Coverage and Member Handbook.

Please Note: All Copayments, Deductibles, and Coinsurance paid for In-Network Covered Services contribute to the In-Network, Out-of-Pocket Maximum.

Dependent Eligibility

Eligible dependents include the employee's spouse (same sex or opposite sex) and dependent children until the child reaches age 26. Benefits discontinue at the end of the month that dependent children turn 26. Teaching Assistants who do not work in a computer or science lab do not have coverage for their dependents.

Domestic Partners are not covered.