Summary of Medical Plan Benefits

This chart summarizes the benefits under the ABC Company Medical Plan's three coverage options. It is only a summary; details are included elsewhere in this booklet.

All benefits are limited to the "usual and customary (U&C) charge," as determined by the claims administrator. You are responsible for paying any amounts that are above the U&C limit. However, charges from preferred providers (in-network) in the Standard and Plus PPO coverage options are always within the U&C limit.

Only "medically necessary" treatment is covered by the Medical Plan. If you receive treatment that is not considered medically necessary by the claims administrator, charges for that treatment must be paid by you, not by the Medical Plan.

	Standard PPO		Plus PPO		Out-of-Area (OOA)
	Preferred Providers (in-network)	**Non-preferred Providers* (out-of-network)**	**Preferred Providers (in-network)**	**Non-preferred Providers* (out-of-network)**	**Any provider***
Deductible *(Rx calendar year deductible is separate)*	• Individual: $400 • Family: $1,200	• Individual: $800 • Family: $2,400	• Individual: $200 • Family: $600	• Individual: $400 • Family: $	• Individual: $150
Out-of-Pocket Limit *(does not include copayments, deductibles, or benefits for mental health /substance abuse)*	• Individual: $2,000 • Family: $6,000	• Individual: $4,000 • Family: $12,000	• Individual: $1,000 • Family: $3,000	• Individu $3,000 • Family: $9,000	
Plan Benefit Percentage *(most covered expenses)*	80% after deductible	60% after deductible	90% after deductible	70% after deductible	80% after deductible
Office Visits	You pay 20% after deductible, plan pays the rest	You pay 40% after deductible, plan pays 60%	You pay $15 copayment, plan pays the rest	You pay 30% after deductible, plan pays 70%	You pay 20% after deductible, plan pays 80%
Preventive Care *(benefits limited to $350 per calendar year)*	You pay 20% after deductible, plan pays the rest	You pay 40% after deductible, plan pays 60%	Included with office visits	You pay 30% after deductible, plan pays 70%	You pay 20% after deductible, plan pays 80%

This traditional benefit summary chart allows the reader to compare the benefits in each coverage option, side-by-side. It is designed to help the employee choose a coverage option during open enrollment.

How the Medical Plan Works

All the coverage options of the ABC Company Medical Plan cover the same medical treatments ("covered expenses"). The options differ by the amount of benefit they pay for these covered expenses.

In-Network and Out-of-Network Benefits

The Standard PPO and PPO Plus coverage options offer you two levels of benefits:

- In-network benefits are provided when you use a "preferred provider" for your care. Preferred providers are doctors, hospitals, clinics, and other health care providers who are part of the UnitedHealthcare PPO network. In-network benefits are generally greater than out-of-network benefits.
- Out-of-network benefits are from health care providers who are *not* members of the UnitedHealthcare PPO network. Out-of-network benefits are generally less than in-network benefits.

The Out-of-Area coverage option provides only one level of benefits.

You may obtain a list of "preferred providers" at no cost by calling the UnitedH Customer Service Line at 866-317-6368, or online at www.myuhc.com.

Hyperlinks are included for each cross-reference, and they update automatically when the SPD is revised.

Copayment

A "copayment" is a flat amount you pay the provider for some s of care, such as in-network office visits or prescription drugs. When you pay a copay t to a provider for care, the plan pays the rest of your covered expenses for that care.

The Medical Plan's copayments are shown in both the benefit summary chart and the section titled Covered Expenses - Medical Plan.

Common Inpatient Covered Expenses

This section describes the most common covered expenses for inpatient treatment. For each type of covered expense, a table shows the expense that you pay and that the plan pays under all three coverage options.

Hospital Treatment

The plan pays benefits for covered expenses incurred for an inp
from the hospital must be for:

- Supplies and services (other than from physicians) rece
- Semi-private room and board charges (i.e., a room with more than one bed).

You must notify Care Coordination for all hospital admissions in order to avoid a benefit penalty. See the section titled Care Coordination for details. If you do not notify Care Coordination, the plan will impose a benefit penalty that reduces your total covered expenses for the hospital treatment by 50% before paying benefits. You must notify Care Coordination:

- At least five days before an *elective admission*
- Within one day of a *non-elective admission*
- As soon as reasonably possible for an *emergency admission*.

Charges for physician services in connection with a hospital admission are billed separately from the hospital charges. Those covered expenses are described in the section titled Inpatient Professional Fees.

Hospital Treatment	Standard PPO		Plus PPO		Out-of-Area (OOA)
	Preferred Providers (in-network)	Non-preferred Providers* (out-of-network)	Preferred Providers (in-network)	Non-preferred Providers* (out-of-network)	Any provider*
You pay	20% after deductible	40% after deductible	1 after deduct	30% after deductible	20% after deductible
Plan pays	the remainder	60%	the remainde	70%	80%

** These benefits are limited to the U&C charge*

Pre-cert information repeats with each applicable covered expense. The employee does not need to read the entire SPD to understand this requirement.

The charts in the "Covered Expenses" section differ from the summary chart. These show how the plan and employee share expenses, even with a "quick skim" reading.