

Highmark Companies

UHC Plan Comparisons

August 2020

Carrier Plan	United Healthcare HDHP - HSA Qualified		United Healthcare Base Plan		United Healthcare Buy-Up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Contract Year	Contract		Contract		Contract	
Preventive Care	100%	70%*	100%	70%*	100%	70%*
Office Visit	PCP: 80%* Specialist: 80%* Virtual: 80%*	PCP: 60%* Specialist: 60%* Virtual: 60%*	PCP: 80%* Specialist: 80%* Virtual: 80%*	PCP: 50%* Specialist: 50%* Virtual: 50%*	PCP: \$0 Copay (Age 0-18) \$25 Copay (Age 19+) Specialist: \$50 Copay Virtual: \$10 Copay	PCP: 60%* Specialist: 60%* Virtual: 60%*
Prescription Drugs	Enhanced Preventive: 100% All Other: 80%* (Advantage)	Enhanced Preventive: 100% + charge over in-network allowed amount All Other: 80%* + charge over in-network allowed amount (Advantage)	Retail: \$15/\$45/\$85 Mail: 2.5 x Copay (Advantage)	Copay + charge over in-network allowed amount (Advantage)	Retail: \$15/\$45/\$85 Mail: 2.5 x Copay (Advantage)	Copay + charge over in-network allowed amount (Advantage)
Emergency Room	80%*	80%*	80%*	80%*	\$350 Copay	\$350 Copay
Urgent Care	80%*	60%*	80%*	50%*	\$50 Copay	60%*
Inpatient Care	80%*	60%*	80%*	50%*	80%*	60%*
Outpatient Care	\$500 POD, than 80%* ¹	\$500 POD, than 60%* ¹	\$500 POD, than 80%* ¹	\$500 POD, than 50%* ¹	\$500 POD, than 80%* ¹	\$500 POD, than 60%* ¹
Annual Deductible	\$3,000/\$6,000 (Embedded - \$3,000)	\$6,000/\$12,000 (Embedded - \$6,000)	\$1,000/\$2,000	\$2,000/\$4,000	\$1,000/\$2,000	\$2,000/\$4,000
Out of Pocket Maximum	\$6,500/\$13,000 (Embedded - \$6,500)	\$13,000/\$26,000 (Embedded - \$13,000)	\$5,000/\$10,000	\$10,000/\$20,000	\$4,000/\$8,000	\$8,000/\$16,000
Eligibility	30 Hours / Week, Legal Spouses & Domestic Partners		30 Hours / Week, Legal Spouses & Domestic Partners		30 Hours / Week, Legal Spouses & Domestic Partners	
Vision Exam (once every 12 months)	\$10 Copay	Up to \$40 Allowance	\$10 Copay	Up to \$40 Allowance	\$10 Copay	Up to \$40 Allowance
Vision Frames (once every 12 months)	\$25 Copay + up to \$130 Allowance plus discount over remaining balance	Frames: Up to \$45 Allowance Single: Up to \$40 Allowance Bifocal: Up to \$60 Allowance Trifocal: Up to \$80 Allowance Lenticular: Up to \$80 Allowance	\$25 Copay + up to \$130 Allowance plus discount over remaining balance	Frames: Up to \$45 Allowance Single: Up to \$40 Allowance Bifocal: Up to \$60 Allowance Trifocal: Up to \$80 Allowance Lenticular: Up to \$80 Allowance	\$25 Copay + up to \$130 Allowance plus discount over remaining balance	Frames: Up to \$45 Allowance Single: Up to \$40 Allowance Bifocal: Up to \$60 Allowance Trifocal: Up to \$80 Allowance Lenticular: Up to \$80 Allowance
Vision Lenses (once every 24 months)		Up to \$105 Allowance		Up to \$105 Allowance		Up to \$105 Allowance

*Coverage provided after deductible.

¹Services provided at a Freestanding Facility or Physician's Office will not be subject to a per occurrence deductible.

Notes: Benefits illustrated above are high level benefits only. Plan documents supersedes this exhibit if there are any discrepancies.

