WASHINGTON COLLEGE
COMPARISON OF HEALTH PLAN OPTIONS FROM UNITED HEALTH CARE (UHC)
EFFECTIVE JULY 1, 2011 -- JUNE 30, 2012

Covered Medical Services, Benefit Limitations, and Exclusions are Identical in All Plan Options.
Principal Differences in Plan Options include Premium Cost, Deductible & Copay Amounts, Coinsurance Rates, and Out of Network Options.

Health Plan Benefits	**MD Choice** HMO - No Referrals Required UHC Plan 9DO Modified	**MD Choice Plus (Low Option)** Lower Prem & Higher Out of Pkt UHC Plan 6DO Modified	**MD Choice Plus (High Option)** Higher Prem & Lower Out of Pkt UHC Plan 7EB Modified
Biweekly Employee Premiums			
Employee Only	$16.10	$20.47	$48.37
Employee + Spouse or Domestic Partner	$122.94	$202.60	$248.87
Employee + Child(ren)	$81.77	$157.61	$199.34
Employee + Family	$237.97	$339.27	$399.33
Employee + Family (Earning less than $28,000/yr)	$227.97		
Annual Deductibles			
In Network - Individual	$0.00	$100.00	$0.00
In Network - Family	$0.00	$200.00	$0.00
Out of Network - Individual (In Addition to In Network Ded)		$400.00	$250.00
Out of Network - Family (In Addition to In Network Ded)	No Coverage, Except Emergency	$800.00	$500.00
In Network Copay Schedule for Common Services	**In Network**	**In Network**	**In Network**
Primary Care Physician Office Visit	100% after $15 Copay	100% after $20 Copay	100% after $20 Copay
Specialist Physician Office Visit	100% after $20 Copay	100% after $20 Copay	100% after $20 Copay
Inpatient Hospital Admission	100% with No Copay	90% after Deductible	100% with No Copay
Physician's Fees For Surgical & Medical Services	100% with No Copay	90% after Deductible	100% with No Copay
Surgery - Outpatient	100% with No Copay	90% after Deductible	100% with No Copay
Urgent Care Center	100% after $50 Copay	Same as HMO	Same as HMO
Emergency Room Outpatient (Not Admitted)	100% after $75 Copay	Same as HMO	Same as HMO
Travel in Foreign Countries	Emergency Coverage Only	Emergency Coverage Only	Emergency Coverage Only
Out of Network Copay Schedule for Common Services	**Out of Network**	**Out of Network**	**Out of Network**
Primary Care Physician Office Visit	No Coverage	70% after Deductible	80% after Deductible
Specialist Physician Office Visit	No Coverage	70% after Deductible	80% after Deductible
Inpatient Hospital Admission	No Coverage, Except Emergency	70% after Deductible	80% after Deductible
Physician's Fees For Surgical & Medical Services	No Coverage, Except Emergency	70% after Deductible	80% after Deductible
Surgery - Outpatient	No Coverage, Except Emergency	70% after Deductible	80% after Deductible
Urgent Care Center	No Coverage, Except Emergency	70% after Deductible	80% after Deductible
Emergency Room Outpatient (Not Admitted)	Same as In Network	Same as In Network	Same as In Network
Travel in Foreign Countries	Emergency Coverage Only	Emergency Coverage Only	Emergency Coverage Only

Health Plan Benefits	MD Choice HMO - No Referrals Required UHC Plan 9DO Modified	MD Choice Plus (Low Option) Lower Prem & Higher Out of Pkt UHC Plan 6DO Modified	MD Choice Plus (High Option) Higher Prem & Lower Out of Pkt UHC Plan 7EB Modified
Coinsurance (Amount Plan Pays After Deductible & Copay)			
In Network (for Services Other than Office Visits)	100% with No Deductible	90% After Deductible	100% with No Deductible
Out of Network	No Coverage, Except Emergency	70% After Deductible	80% After Deductible
Out of Pocket Maximum (Inc Deductibles, Ex Copays)			
In Network - Individual	Plan Pays 100%	$1,400.00	$1,300.00
In Network - Family	Plan Pays 100%	$2,800.00	$2,600.00
Out of Network - Individual (In Addition to In Network Max)	No Coverage, Except Emergency	$2,400.00	$2,250.00
Out of Network - Family (In Addition to In Network Max)	No Coverage, Except Emergency	$4,800.00	$4,500.00
Maximum Benefit (Both Plan Year and Lifetime Max)			
In Network	No Maximum	$5,000,000	$5,000,000
Out of Network	No Coverage, Except Emergency	Combined In/Out of Network Limit	Combined In/Out of Network Limit
Prescription Drug Copayments (Retail up to 31 Days)			
Tier I Drugs (Generally Generic Drugs)	$10.00	$10.00	$10.00
Tier II Drugs (Generally Formulary Preferred Drugs)	$30.00	$30.00	$25.00
Tier III Drugs (Generally Formulary Non-Preferred Drugs)	$50.00	$50.00	$45.00
Prescription Drug Copayments (By Mail up to 90 Days)			
Tier I Drugs (Generally Generic Drugs)	$25.00	$25.00	$25.00
Tier II Drugs (Generally Formulary Preferred Drugs)	$75.00	$75.00	$62.50
Tier III Drugs (Generally Formulary Non-Preferred Drugs)	$125.00	$125.00	$112.50

Footnotes & Disclaimers:

1) **Covered Health Services, benefit limitations, and exclusions are <u>identical</u> in all three plans**. The principal differences among Plans include premium costs, deductible & copay amounts, coinsurance rates, and whether coverage is restricted to in network providers or whether out of network providers are permitted.
2) **MD Choice** is an "open referral" HMO. The Plan has a National Network of Providers, but does not require referrals from your primary care physician to see a specialist, provided you use Network physicians. There is NO coverage for medical care provided outside the Network of Providers, except certain emergency care.
3) **MD Choice Plus (Low Option)** is a Point of Service Plan (POS). The Plan has the same National Network of Providers as the HMO. POS plans permit employees to select physicians in network or out of network, but out of network costs are significantly higher. The Low Option has lower premiums & higher out of pocket costs.
4) **MD Choice Plus (High Option)** is a Point of Service Plan (POS). The Plan has the same National Network of Providers as the HMO. POS plans permit employees to select physicians in network or out of network, but out of network costs are significantly higher. The High Option has higher premiums & lower out of pocket costs.
5) **UHC Benefit Summaries**. This comparison of UHC Plan Options was prepared by Human Resources and approved by UHC. This is a "high level summary" to facilitate Plan comparisons. Detailed UHC Benefit Summaries are available at **http://hr.washcoll.edu/benefits_medicalinsurance.php** or on request from Human Resources.
6) **Certificate of Coverage**. UHC will provide a Master Certificate of Coverage to Human Resources for each Plan. Certificates of Coverage will be posted on HR's website. If differences arise between this comparison or UHC Benefit Summaries and the Certificate of Coverage, the Certificate of Coverage will be the controlling document.
7) **Provider Networks**. Employees can find out if their current physician is a participating provider in the HMO or POS Networks by going to **www.myuhc.com**. Login is not required. Select "Find a Physician or Facility"; then Select "UHC Choice" for the HMO network or "UHC Choice Plus" for the POS network.

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Additional Core Benefits (In Network / Out of Network)			
Acupuncture	100% > $20 up to 12 Visits	100% > $20 up to 12 Visits / 70%	100% > $20 up to 12 Visits / 80%
Ambulance (Air/Ground) - Emergency	100%	90% / 90% after Ded	100% / 100%
Ambulance (Air/Ground) - NonEmergency	100% w/ Precertification	90% / 90% after Ded	100% / 100%
Congenital Heart Disease Surgery	100% after $50 Copay	90% / 70% up to $30k	100% / 80% up to $30k
Dental Services (Accident Only)	100% up to $900/tooth	Same but 90% / 70% after Ded	100% up to $900/tooth
	100% up to $3,000/yr	Same but 90% / 70% after Ded	100% up to $3,000/yr
Diabetes Services Diagnostic/Training	Covered Health Service	Same but 90% / 70% after Ded	Covered Health Service
Diabetes Self Management Equipment	Durable Medical Equip	Same but 90% / 70% after Ded	Durable Medical Equip
Diabetes Self Management Drugs	Prescription Drug Benefit	Same but 90% / 70% after Ded	Prescription Drug Benefit
Durable Medical Equipment (In Network / Out of Network)	100% up to $5,000/yr	Same but 90% / 70% after Ded	Same but 100% / 80%
Home Health Care	100% up to 60 visits/yr	Same but 90% / 70% after Ded	Same but 100% / 80%
Hospice Care	100%	90% / 70% after Ded	100% / 80%
Infertility Services (Precertification Required)	50%	50% / 50% after Ded	50% / 50% after Ded
Lab & X-Ray - Diagnostic Outpatient	100%	100% No Ded / 70% after Ded	Same but 100% / 80%
Lab & X-Ray - Major Diagnostics	100%	90% / 70% after Ded	Same but 100% / 80%
Ostomy Supplies	100% up to $2,500/yr	Same but 90% / 70% after Ded	Same but 100% / 80%
Pharmaceutical Products - Outpatient	100%	90% / 70% after Ded	100% / 80%
Physician's Fees For Surgical & Medical Services	100% after $25 Copay	90% / 70% after Ded	100% / 80%
Pregnancy - Maternity Services	Covered Health Service	Covered Health Service	Covered Health Service
* Newborn Hospital Deductible	$0 if Child's Stay = Mother's Stay	Same	Same
* Newborn Physician Office Copay	$15/$20 Copay	$20 Copay	$20 Copay
Prosthetic Devices	100% up to $5,000/yr	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
Reconstructive Procedures	Covered Health Service	Same	Same
Rehabilitation Services	100% after $20 Copay	100%>$20 Copay / 70% after Ded	100%>$20 Copay / 80% after Ded
* Cardiac Rehab	Up to 36 visits.	Same	Same
* Chiropractic Therapy	Up to 20 visits.	Same	Same
* Cleft Lip or Palate	Up to 20 visits.	Same	Same
* Occupational Therapy	Up to 20 visits.	Same	Same
* Physical Therapy	Up to 20 visits.	Same	Same
* Post-Cochlear Implant Aural Therapy	Up to 30 visits.	Same	Same
* Pulmonary Therapy	Up to 20 visits.	Same	Same
* Speech Therapy	Up to 20 visits.	Same	Same
Scopic Procedures - Outpatient			
* Colonoscopy	100%	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
* Endoscopy	100%	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
* Sigmoidoscopy	100%	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
Skilled Nursing	100% after $50 Copay	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
* Up to 60 days per year			
Surgery - Outpatient	100%	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
Therapeutic Treatments - Outpatient			
* Dialysis	100%	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
* IV Chemotherapy or Other Infusion	100%	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded

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* Radiation Oncology	100%	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
Transplantation Services (Precert Req.)	100% after $50 Copay	90% / 70% up to $30k after Ded	100% / 80% up to $30k after Ded
Vision Examinations	100% > $20 Copay	100% > $20 Copay / 70%	100% > $20 Copay / 80%
* Vision Exam Limit	1 Exam every 2 yrs	Same	Same

State of Maryland Mandated Benefits	CHS = Covered Health Svc		
Amino Acids	100%	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
Bones of Face, Neck, Head	CHS, without Plan Limit	Same	Same
Child Hearing Aids	100% up to $1400/ear/3yrs	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
Child Wellness Services	CHS, without Plan Limit	Same	Same
Clinical Trial Costs	CHS, without Plan Limit	Same	Same
Dental Services (Hospital Care)	CHS, without Plan Limit	Same	Same
Habilitative Services	CHS, without Plan Limit	Same	Same
Hair Prosthesis	100% up to $350	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
In Vitro Fertilization	CHS, without Plan Limit	Same	Same
	Up to 3 attempts/live birth<$100k	Same	Same
Medical Foods	100%	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
Mental Health & Substance Abuse - Inpatient	100% after $50 Copay	Same but 90% / 70% after Ded	Same but 100% / 80% after Ded
Mental Health & Substance Abuse - Outpatient	80% for Visits 1 - 5/yr	Same	Same
	65% for Visits 6 - 30/yr	Same	Same
	50% for Visits Over 30/yr	Same	Same
Surgical Morbid Obesity Treatment	CHS, without Plan Limit	Same	Same
Treatment of Cleft Lip or Palate or Both	CHS, without Plan Limit	Same	Same

Medical Exclusions (See UHC Benefit Summary)
The following treatments and procedures are excluded from all Plan Options:

Alternative Treatments	Services Provided by Family Members or Self
Dental Care (Not resulting from Covered Health Service)	Skin Procedures & Treatments (Plastic Surgery)
Devices, Appliances, & Prosthetics	Reproduction Services except In Vitro Fertilization
Drugs, Except as Provided in Drug Plan	Transplants, except Transplantation Specified
Experimental or Investigational Services	Travel in Foreign Country except Emergency
Foot Care	Types of Care Excluded (See UHC Benefit Summary)
Hearing Products	* Pain Management on Inpatient Basis
Medical Supplies	* Custodial or Domiciliary Care
Mental Health Services Not Classified in APA DSM Manual	* Private Duty Nursing
Nutrition except for Disease Management	* Respite Care
Personal Care, Comfort, or Convenience	* Work Hardening
Physical Appearance (Cosmetic Procedures)	Vision Products
Services Covered under Another Health Plan	All Services Not Defined as Covered Health Services

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