Medical Plan Grid

	Conventional Medical Plan (CMP)		Consumer Choice 2000		Consumer Choice 4000	
PROVISION/BENEFIT	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	$1,500 single $3,000 employee +spouse $3,000 employee + child(ren) $4,500 family	$3,000 single $6,000 employee + spouse $6,000 employee + child(ren) $9,000 family	$2,000 single $3,000 employee + spouse $3,000 employee + child(ren) $4,000 family	$2,000 single $3,000 employee + spouse $3,000 employee + child(ren) $4,000 family	$4,000 single $6,000 employee + spouse $6,000 employee + child(ren) $8,000 family	$4,000 single $6,000 employee + spouse $6,000 employee + child(ren) $8,000 family
	Please note that the annual deductible and annual out-of-pocket limits are determined by the level of coverage you have elected. Under the CMP, each family member has a maximum individual annual deductible of $1,500; all dependents covered under the family together will not pay more than a deductible of $4,500 (in-network). The same applies to the annual out-of-pocket limits listed below. Each family member has an individual annual out-of-pocket limit of $4,000 (in-network); all dependents covered under the family together will not have annual out-of-pocket expenses greater than $12,000 (in-network).		*Please note that the annual deductible and annual out-of-pocket limits are determined by the level of coverage you have elected. Under the Consumer Choice 2000 plan, each family member has an individual annual out-of-pocket limit of $7,150 (in-network); all dependents covered under the family together will not have annual out-of-pocket expenses greater than $8,000 (in-network).*		*Please note that the annual deductible and annual out-of-pocket limits are determined by the level of coverage you have elected. Under the Consumer Choice 4000 plan, each family member has an individual annual out-of-pocket limit of $7,150 (in-network); all dependents covered under the plan will not have annual out-of-pocket expenses greater than $9,000 or $12,000 depending on your coverage level (in-network).*	
Annual Out-of-Pocket Limit ***(includes deductible & co-pays)***	$4,000 single $8,000 employee + spouse $8,000 employee + child(ren) $12,000 family	$7,500 single $15,000 employee + spouse $15,000 employee + child(ren) $22,500 family	$4,000 single $6,000 employee + spouse $6,000 employee + child(ren) $8,000 family (individual is limited to $7,150)	$5,000 single $10,000 employee + spouse $10,000 employee + child(ren) $15,000 family	$6,000 single $9,000 employee + spouse $9,000 employee + child(ren) $12,000 family (individual is limited to $7,150)	$8,000 single $12,000 employee + spouse $12,000 employee + child(ren) $16,000 family
Annual Maximum Benefit Limit (combined In- and Out-of-Network)	Unlimited		Unlimited		Unlimited	
Lifetime Maximum Benefit Limit (combined In- and Out-of-Network)	Unlimited		Unlimited		Unlimited	
Health Savings Account	Does not apply		Plexus will allocate up to $650 per year for single coverage and $1,000 for all other coverage levels; the amount is pro-rated on a per paycheck basis.		Plexus will allocate up to $650 per year for single coverage and $1,000 for all other coverage levels; the amount is pro-rated on a per paycheck basis.	
(To be eligible for an HSA, you must meet eligibility requirements as defined by the IRS. Visit www.irs.gov for more details.)			*Please note that if you are enrolled in another medical plan i.e. your spouse's non-high deductible health plan, a military plan or Medicare, you are not eligible for contributions to a Health Savings Account.*		*Please note that if you are enrolled in another medical plan i.e. your spouse's non-high deductible health plan, a military plan or Medicare, you are not eligible for contributions to a Health Savings Account.*	

Neither of the Consumer Choice Plans or Conventional Medical Plan is considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act).

	Conventional Medical Plan (CMP)		Consumer Choice 2000		Consumer Choice 4000	
PROVISION/BENEFIT	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Professional Services	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**
Physician Primary Care	$30 co-pay, then 20% of charges* (excludes diagnostic x-ray and lab)	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Physician Specialist Care	$60 co-pay, then 20% of charges* (excludes diagnostic x-ray and lab)	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Urgent Care Services	$50 co-pay, then 20% of charges*	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Inpatient Hospital Physician / Anesthesiologist Services	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Diagnostic Testing, Radiology, Pathology and Anesthesiology Services	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Allergy Testing, Serum/Vials and Injections	$0; (100% covered)	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospital Services	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**
Inpatient Services Includes room and board (semi-private room) x-rays, labs, miscellaneous hospital expenses	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Surgery Performed in Hospital or Surgery Center	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Diagnostic Tests, Radiology, Pathology and Anesthesiology	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Emergency Room Visit – *Emergency* (co-pay waived if admitted)	$250 co-pay, then 20% of charges*	$250 co-pay then 20% of charges*	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Emergency room visit – *non-emergency*	40% after deductible	40% after deductible	40% after deductible	40% after deductible	40% after deductible	40% after deductible
Preventive Services	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**
Routine Medical Exams including Well Baby Care **Immunizations** including Flu Shots **Diagnostic Services** including Mammograms, Pap Smears, PSA Test, Colonoscopies	$0 (100% Covered) Deductible does not apply	$0 (100% Covered) Deductible does not apply	$0 (100% Covered) Deductible does not apply	$0 (100% Covered) Deductible does not apply	$0 (100% Covered) Deductible does not apply	$0 (100% Covered) Deductible does not apply
	Please note that preventive and diagnostic mammograms and colonoscopies are covered at 100% following USPSTF guidelines. Other procedures are processed according to plan provisions.		*Please note that preventive and diagnostic mammograms and colonoscopies are covered at 100% following USPSTF guidelines. Other procedures are processed according to plan provisions.*		*Please note that preventive and diagnostic mammograms and colonoscopies are covered at 100% following USPSTF guidelines. Other procedures are processed according to plan provisions.*	

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	Conventional Medical Plan (CMP)		Consumer Choice 2000		Consumer Choice 4000	
PROVISION/BENEFIT	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Other Covered Health Services	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**
Outpatient Physical, Speech, Occupational, Cardiac and Respiratory Therapy	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Ambulance Services	20%, no deductible*	20%, no deductible*	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prosthetic Devices	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Durable Medical Equipment *Prior-Auth required for Non-Network devices that cost over $1,000*	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Skilled Nursing Facility *Limited to 90 days per calendar year combined In- and Out-of-Network*	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Chiropractic Care *Limited to 52 visits per calendar year combined In- and Out-of-Network*	$30 co-pay, then 20% of charges*	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Maternity Services including Post-Natal Care	Specialist office visit applies to first visit only	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Pre-Natal Care - initial and subsequent history and physical exams of pregnant woman which may include maternal weight, blood pressure, and fetal heart rate check	$0 (100% Covered); Deductible does not apply If billed globally, no cost share will apply to 40% of the global rate	$0 (100% Covered); Deductible does not apply If billed globally, no cost share will apply to 40% of the global rate	$0 (100% Covered); Deductible does not apply If billed globally, no cost share will apply to 40% of the global rate	$0 (100% Covered); Deductible does not apply If billed globally, no cost share will apply to 40% of the global rate	$0 (100% Covered); Deductible does not apply If billed globally, no cost share will apply to 40% of the global rate	$0 (100% Covered); Deductible does not apply If billed globally, no cost share will apply to 40% of the global rate
Inpatient Room and Board and Physician Delivery fees	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Lactation Support and Counseling	$0 (100% Covered; Deductible does not apply	$0 (100% Covered; Deductible does not apply	$0 (100% Covered; Deductible does not apply	$0 (100% Covered; Deductible does not apply	$0 (100% Covered; Deductible does not apply	$0 (100% Covered; Deductible does not apply
Breast Pumps *See summary plan description for coverage details*	$0 (100% Covered) Deductible does not apply	$0 (100% Covered) Deductible does not apply	$0 (100% Covered); Deductible does not apply	$0 (100% Covered); Deductible does not apply	$0 (100% Covered); Deductible does not apply	$0 (100% Covered); Deductible does not apply
Infertility Services Diagnosis and Treatment of Underlying Condition	20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Artificial Insemination, Ovulation Induction and Advanced Reproductive Technology Services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

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		Conventional Medical Plan (CMP)		Consumer Choice 2000		Consumer Choice 4000	
PROVISION/BENEFIT		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Home Health Care *Limited to 60 visits per calendar year combined in and Out-of-Network*		20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Hospice Care		20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
TMJ Treatment		20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Organ Transplants *See summary plan description for coverage details*		20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Treatment of Alcoholism, Drug Abuse and Nervous or Mental Disorders		**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**	**You Pay**
Nervous & Mental - Inpatient Hospital		20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Nervous & Mental - Outpatient		$30 co-pay then 20% of charges*	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
		No visit limits		No visit limits		No visit limits	
Alcoholism & Drug Abuse - Inpatient Hospital		20% after deductible	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Alcoholism & Drug Abuse - Outpatient		$30 co-pay then 20% of charges*	40% after deductible	20% after deductible	40% after deductible	20% after deductible	40% after deductible
		No visit limits		No visit limits		No visit limits	
Prescription Drugs		**CMP**		**Consumer Choice 2000**		**Consumer Choice 4000**	
		Retail (30 Days)	**Mail (90 Days)**	**Retail (30 Days)**	**Mail (90 Days)**	**Retail (30 Days)**	**Mail (90 Days)**
Preventive Medications	**Generic Tier 1**	0%	0%	0%	0%	0%	0%
	Brand Formulary Tier 2	$35 Min/$150 Max	$87.50 Min/$375 Max	20%	20%	20%	20%
	Non-Formulary Tier 3	$60 Min/$150 Max	$150 Min/$375 Max	20%	20%	20%	20%
Other Medications	**Generic Tier 1**	$10 Min/$150 Max	$25 Min/$375 Max	20%	10%	20%	10%
	Brand Formulary Tier 2	$35 Min/$150 Max	$87.50 Min/$375 Max	20%	10%	20%	10%
	Non-Formulary Tier 3	$60 Min/$150 Max	$150 Min/$375 Max	20%	10%	20%	10%
		Under the CMP, there is a 25% coinsurance which is subject to the minimum and maximum listed above.		All medications under the Consumer Choice plans are subject to the deductible prior to the applications of coinsurance, except for preventive medication.		All medications under the Consumer Choice plans are subject to the deductible prior to the applications of coinsurance, except for preventive medication.	

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Pharmacy Programs (New for 2020)	Choose Generics Step Therapy/Prior Authorization	Choose Generics Step Therapy Core Plus Preventive Medications	Choose Generics Step Therapy Core Plus Preventive Medications

The Medical Plan Grid outlined above serves as a summary of your medical plan options. Please refer to the Summary Plan Descriptions for detailed coverage information.

A higher benefit is provided by using In-Network providers/facilities as opposed to Out-of-Network providers/facilities. To **search for In-Network providers/facilities**, go to www.myuhc.com and click "Find a Doctor."

* Services with an * **do not apply** to your deductible. The percent of eligible expense you are responsible for will apply to your annual out-of-pocket maximum (except for prescription drugs).

GLOSSARY:

Annual Deductible – The amount you must pay (per calendar year) for eligible services before the medical plan begins to pay benefits. The Medical Plan Grid outlined above indicates which services are subject to the deductible.

Annual Out-of-Pocket Limit – The maximum limit you are responsible for paying (per calendar year) for your portion of the benefits for this plan. This amount is inclusive of your annual deductible.

Co-pay – The **specific** dollar amount you pay, based on the type of service, before additional plan benefits apply. Co-pays only exist for the CMP. They do not apply towards your deductible. They do however apply to your Out of Pocket maximum limit.

Explanation of Benefits (EOB) – The document that UHC sends to you summarizing how your claim was processed including applicable network discounts associated with using in-network providers, how much of the claim you are responsible for, how much of the claim the plan is responsible for. Please note, this is not a bill; you should wait to receive a bill from your provider prior to making payment.

In-Network – Discounted services available from a health care provider, facility or pharmacy that has contracted with UHC, an affiliate, or a third-party vendor, to furnish services or supplies at a reduced rate for this plan.

Out-of-Network – Non-discounted services from a health care provider, facility or pharmacy that has NOT contracted with UHC, an affiliate, or a third-party vendor, to furnish services or supplies at a reduced rate for this plan.