Health Savings Account Plan (HDHP)

Annual Deductible	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Deductible per person *(one individual member only)*:	$3,300	$3,300	**N/A**
Deductible per family *(two or more members)*:	$6,600	$6,600	
	Benefits must be shown below for coverage for UHC Choice Plus		
Coinsurance	**Primary Network: HonorHealth/ICP**	**Secondary Network: UHC Choice Plus**	**Out of Network No coverage unless otherwise listed**
Paid by Plan after satisfaction of the deductible:	80%	80%	**N/A**
Annual Out-of-Pocket Maximum	**Primary Network: HonorHealth/ICP**	**Secondary Network: UHC Choice Plus**	**Out of Network No coverage unless otherwise listed**
Out-of-pocket maximum per person* *(one individual member only)*:	$6,450	$6,450	**N/A**
Out-of-pocket maximum per family* *(two or more members):*	$12,900	$12,900	**N/A**
Do out-of-pocket maximums cross-feed between all benefit tiers?	Yes		
Does the deductible apply to the out-of-pocket maximum?	Yes		
Is the out-of-pocket integrated with pharmacy?	Yes		

Summary of Benefits

Durable Medical Equipment

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover durable medical equipment?	Yes	Yes	No
Apply deductible?	Yes	Yes	
Paid by Plan:	80%	80%	

Orthotics

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover orthotics?	Yes	Yes	No
Apply deductible?	Yes	Yes	
Paid by Plan:	80%	80%	

Prosthetics

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover prosthetics?	Yes	Yes	No
Apply deductible?	Yes	Yes	
Paid by Plan:	80%	80%	
Comments: Mastectomy Bras & camisoles are limited to 6 per calendar year, combined.			

Extended Care Facility

(Services such as skilled nursing, acute inpatient rehabilitation, convalescent care, or sub-acute facility)

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover extended care facility services?	Yes	Yes	No
Apply deductible?	Yes	Yes	
Paid by Plan:	80%	80%	
Maximum days per: Calendar year	*120 days for both Primary and Secondary Networks*		

Hearing Hardware

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
External Hearing Aids and Fittings			
Does the Plan cover external hearing aids and fittings?	Yes	Yes	No
Apply deductible?	Yes	Yes	
Paid by Plan:	80%	80%	
	$2,500 per ear every 3 years Includes hearing aids, repairs, initial batteries, & related supplies		
Implantable Hearing Devices			
Does the Plan cover implantable hearing devices?	Yes	Yes	No
Apply deductible?	Yes	Yes	
Paid by Plan:	80%	80%	

Home Health Care

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover home health care services?	Yes	Yes	No
Apply deductible?	Yes	Yes	
Paid by Plan:	80%	80%	
Maximum visits per: Calendar year		120	
Home infusion will utilize the same benefit as home health care.			
Comments: Home infusion for Secondary Network will not be covered			

Hospice Care

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover hospice care?	Yes	Yes	No
Apply deductible?	Yes	Yes	
Paid by Plan:	80%	80%	
Allow bereavement counseling?	Yes, Bereavement services must be furnished within 6 months of death.		

Ambulance and other Medically Necessary Transportation (ground and air)

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover ambulance services?	Yes	Yes	Yes
Apply deductible?	Yes	Yes	Yes
Paid by Plan:	80%	80%	80%

Emergency Room
(Includes physician and facility charges)

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover emergency room services?	Yes	Yes	Yes
Apply deductible?	Yes	Yes	Yes
Paid by Plan:	80%	80%	80%

Hospital services in an Inpatient Setting
(Includes physician and facility charges)

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover inpatient hospital services?	Yes	Yes	Yes
Apply deductible?	Yes	Yes	Yes
Paid by Plan:	80%	80% Emergency Admission Only**	80% Emergency Admission Only

****And approved services at Phoenix Children's Hospital**

Hospital Services in an Outpatient Setting
(Includes physician and facility charges)

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover outpatient hospital services?	Yes	No**	No
Allow x-ray & ultrasounds *(Excludes outpatient imaging)*	Yes	Yes	No
Apply deductible?	Yes	Yes	
Paid by Plan:	80%	80%	

Allow lab? Apply deductible? Paid by Plan:	Yes Yes 80%	Yes Yes 80%	No
Allow outpatient charges for advanced imaging? *(PET/CT/MRI/MRA and nuclear medicine)* Apply deductible? Paid by Plan:	Yes Yes 80%	Yes Yes 80%	No
Allow outpatient surgery? Apply deductible? Paid by Plan:	Yes Yes 80%	No	No
Allow all other outpatient services? Apply deductible? Paid by Plan:	Yes Yes 80%	No	No

****And approved services at Phoenix Children's Hospital**

Urgent Care

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover urgent care? Apply deductible? Paid by Plan:	Yes Yes 80%	Yes Yes 80%	No

Walk-In Retail Health Clinics

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover walk-in retail health clinics? Apply deductible? Paid by Plan:	Yes Yes 80%	Yes Yes 80%	No

Telehealth/Virtual Visits

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover telehealth? Apply deductible? Paid by Plan:	Yes Yes 80%	Yes Yes **PCP/Pediatrician:** 80% **Other PCP:** no coverage **Perinatologists, & Pediatric Specialists:** 80% **Other Spec:** no coverage	No

Infertility

Summary of Benefits	
Does the Plan cover infertility?	Yes Cover direct attempts to cause pregnancy by any means including, but not limited to, hormone or therapy drugs.
Maximum benefit per: ☒ Lifetime	$10,000 per plan participant per lifetime.. Limit applies only to treatment & not office visits.
Does the Plan cover infertility drugs? *If yes, infertility drugs are covered under the:*	Yes ☐ Medical Plan ☒ Pharmacy Plan with a $10,000 lifetime limit
Comments: **Secondary Network and Out of Network: no coverage**	

Medical Office Visit

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover medical office visits?	Yes	Yes	No
Apply deductible?	Yes	Yes	
Paid by Plan:	80%	80%	
UMR considers the following provider specialties to be primary care physicians (PCPs): family practitioner, general practitioner, internal medicine, pediatrics, OBGYN, nurse practitioner, physician assistant, and mental health/substance use providers. (Any specialty not listed here will be considered a specialist)			

Mental Health and/or Substance Use

Summary of Benefits	
Does the Plan cover mental health and/or substance use?	Yes **Mental Health Outpatient services:** Primary and Secondary Network: 80% after deductible; Out of Network: no coverage. **Mental Health Inpatient services:** Primary and Secondary Network: 80% after deductible; Out of Network: No coverage.
Does the Plan cover autism*? .	Yes **Habilitation Services:** Services are only covered for ABA Therapy for Autism. Primary and Secondary Network: 80% after deductible; Out of Network: No coverage.
Services performed in a physician's office will be paid according to the benefits outlined in the medical office visit section of this form. Services performed in a hospital will be paid according to the benefits outlined in the hospital section.	

Pregnancy

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover pregnancy services? Note: Secondary Network coverage will be allowed at the Primary Network level of benefit for a services provided by the following: • Certified Nurse Midwife • Lactation Consultants All other Maternity services: no coverage for Secondary Network and Out of Network.	Yes	No	No
Allow outpatient birthing centers? Allow home deliveries? Allow all elective abortions? *Allow elective abortions if the life of the mother is in danger or as the result of incest or rape?*	Yes Yes No Yes		
Male Sterilization			
Allow sterilization for men?	Yes	No	No

Note: Newborn charges will be processed under the newborn.

Services performed in a physician's office will be paid according to the benefits outlined in the medical office visit section of this form. Services performed in a hospital will be paid according to the benefits outlined in the hospital section of this form.

Preventive/Routine Care

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover preventive/routine care? *If yes,* Apply deductible? Paid by Plan: ****Only Pediatric visits Preventive/Routine Care are covered through the Secondary Network. All other Preventive/Routine services must be performed by a Primary Network provider.**	Yes No 100%	Yes No 100%	No

Private Duty Nursing

(Outpatient)

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover private duty nursing?	No	No	No

Temporomandibular Joint Disorder Benefits

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover temporomandibular joint disorders?	Yes	Yes	No
If yes, what services should be covered?	☒ All services *(diagnostic, non-surgical treatment [includes appliances and adjustments], surgery)*		
Apply deductible? Paid by Plan: Maximum benefit per: No benefit maximum	Yes 80%	Yes 80%	

Manipulations

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover manipulations? Apply deductible? Paid by Plan:	Yes Yes 80%	Yes Yes 80%	No
Maximum visits per: ☒ Calendar year*	20 combined with acupuncture and natouropathic care		

Physical and Occupational Therapy (*Outpatient and office*)

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover physical and occupational therapy?	Yes	Yes	No
Outpatient and Office Therapy			
Apply deductible? Paid by Plan:	Yes 80%	Yes 80%	

Speech Therapy *(Outpatient and office)*

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover speech therapy?	Yes	Yes	No
Outpatient and Office Therapy			
Apply deductible? Paid by Plan:	Yes 80%	Yes 80%	

Other Items/Services

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Acupuncture treatment 20 visits per calendar year, combined with manipulations and naturopathic care.	Covered 80% after deductible	Covered 80% after deductible	Excluded
Alternative/complimentary treatment • Holistic or homeopathic medicine Plan will cover services from a naturopathic provider only.	Covered	Covered	Excluded

20 visits per calendar year, combined with manipulations and acupuncture. • Hypnosis • Other alternative treatment that is not accepted medical practice as determined by the Plan.	80% after dedutible Excluded Excluded	80% after deductible Excluded Excluded	 Excluded Excluded
Augmentation communication devices	Covered	Covered	Excluded
Biofeedback	Covered	Covered	Excluded
Blood pressure cuffs/monitors	Excluded	Excluded	Excluded
Breast reductions based on medical necessity	Covered	Excluded	Excluded
Counseling *Note: Does not include home health or morbid obesity provision.* • Diabetic counseling • Nutritional counseling • Marriage counseling	 Covered Covered Excluded	 Excluded Excluded Excluded	 Excluded Excluded Excluded
Developmental delays Only covered as a direct result of an *injury*, *surgery*, or covered treatment (i.e., covered treatment for down syndrome or autism spectrum disorder) • Occupational therapy • Physical therapy • Speech therapy **Speech therapy for developmental delays requires an allowable medical diagnosis at visit one.* • Medical charges	 Covered Covered Covered Covered	 Covered Covered Covered Covered	 Excluded Excluded Excluded Excluded
Experimental/investigational • Qualifying clinical trial • Life threatening condition exception	 Excluded Excluded	 Excluded Excluded	 Excluded Excluded
Gender dysphoria	Covered	Covered	Excluded
Foot care *Foot care will always be covered if:* ○ *It is done as the result of an infection or disease (i.e.: removal of ingrown toenails).* ○ *Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet, when surgery is performed.* ○ *Physician's office visit for diagnosis of bunions.* ○ *Treatment of bunions when an open cutting operation or arthroscopy is performed.* • Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease • Palliative foot care	 Covered Excluded	 Excluded Excluded	 Excluded Excluded

• Trimming of nails, corns, or calluses when there is not a metabolic disease *(routine)*	Excluded	Excluded	Excluded
Genetic counseling or testing based on medical necessity	Covered	Covered	Excluded
Infant formula *(Administered through a tube as the sole source of nutrition for the covered person)*	Covered	Covered	Excluded
Learning disability	Covered	Covered	Excluded
Wrong surgeries	Excluded	Excluded	Excluded
Nutritional supplements • Enteral feedings *(Administered through a tube as the sole source of nutrition for the covered person)* • Supplies including feeding tubes, pumps, bags, and products. • Supplemental feedings, over-the-counter nutritional and electrolyte supplements. .	Covered Covered Excluded	Covered Covered Excluded	Excluded Excluded Excluded
Orthognathic, prognathic and maxillofacial Surgery	Covered	Covered	Excluded
Panniculectomy *Note: These services will be covered if based on medical necessity.*	Excluded	Excluded	Excluded
Reconstructive surgery *Note: Federally Mandated Breast Reconstruction is always covered.*	Covered	Excluded	Excluded
Congenital defects	Covered	Covered	Excluded
Cosmetic surgery *Note: These services will be covered if based on medical necessity.*	Excluded	Excluded	Excluded
Sales tax for other than DME, shipping and handling	Excluded	Excluded	Excluded
Complications from a non-covered service	Excluded	Excluded	Excluded
Sexual function • Diagnostic • Non-surgical • Surgical • Prescription drugs *(any medications, oral or other, used to increase sexual function or satisfaction or penile pumps and erectaid devices)* **Only treatment for injury or cancer related will be covered**	 Covered Covered Covered Covered	 Excluded Excluded Excluded Excluded	 Excluded Excluded Excluded Excluded
Sleep disorders	Covered	Excluded	Excluded
Sleep studies	Covered	Excluded	Excluded
Tobacco addiction	Covered	Covered	Excluded
Weight control *(morbid obesity)*	Covered	Excluded	Excluded

Morbid obesity means a body mass index (BMI) that is greater than or equal to 40 kg/m2. If there are serious (life-threatening) medical condition(s) exacerbated by or caused by obesity not controlled despite maximum medical Therapy and patient compliance with medical treatment Plan, a BMI greater than or equal to 35 kg/m2 is applied. Morbid obesity for a covered person who is less than 19 years of age means a BMI that falls above the 95th percentile on the growth chart.
• Bariatric surgery, including but not limited to:
  ○ Gastric or intestinal bypasses *(Roux-en-Y; biliopancreatic bypass; biliopancreatic diversion with duodenal switch)*
  ○ Stomach stapling *(vertical banded gastroplasty; gastric banding; gastric stapling)*
  ○ Lap band *(laparoscopic adjustable gastric banding)*
  ○ Gastric sleeve procedure *(laparoscopic vertical gastrectomy; laparoscopic sleeve gastrectomy)*
• Prescription medication needed for weight loss
• Physician supervised weight loss programs at a medical facility
• Diet supplements
• Charges for diagnostic services
• Nutritional counseling by a registered dietician or other qualified provider, if applicable.
If covered, cover for:
☒ Any age
 	
Bariatric surgery coverage is limited to employee & their spouse/partner. Dependents are excluded from coverage.
	Covered
	
	Excluded under the medical plan
	
	Excluded
	Excluded
	Covered
	
	Covered		

Wigs, toupees, hairpieces, etc. for cancer treatment or a medically necessary condition such as alopecia Areata? Apply deductible? Paid by Plan: Maximum benefit per: ☒ Calendar Year	Covered Yes 80%	Covered Yes 80% $500	Covered Yes 80%

Services requiring prior authorization

☒ Inpatient hospitalizations (observations stays greater than 72 hours).
- ☒ Inpatient maternity stays over 48 hours *(normal delivery)* or 96 hours *(c-section)*
- ☒ Inpatient behavioral health
- ☒ Residential treatment
- ☒ Transplant and transplant related services
- ☒ Skilled nursing facilities *(extended care facilities)*

☒ Partial hospital program
☒ Home health care
☒ Home infusion therapy
☒ Durable medical equipment *(excludes braces and orthotics)*
- ☒ Any equipment purchased over $1,000
- ☒ Prosthetics/Orthotics over $2,000

☒ Clinical trials

☒ Bariatric surgery

☒ Dialysis (outpatient)

☒ Additional requirements

- ☒ MRI, MRA,CTA PET Scans
- ☒ Certain Specialty Drugs
- ☒ Outpatient Surgery
- ☒ Physical & Occupational Therapy
- ☒ Speech Therapy
- ☒ Testosterone Hormone Therapy for Men
- ☒ Ventricular Assistive Device (VAD) Life Vest, Implantable Cardiac Defibrillator.
- ☒ Insulin pumps in excess of $1,000
- ☒ Genetic Counseling & Testing & related labs
- ☒ Surgical treatment of TMJ conditions
- ☒ Pain management services (epidurals, implantable infusion pumps)
- ☒ Ambulance Services (non-emergent)
- ☒ Hyperbaric Oxygen Therapy
- ☒ Proton Beam Therapy
- ☒ Adoptive Cell Therapy
- ☒ Cosmetic Procedures (ex: Breast Reductions & Reconstruction, Blepharoplasty, Strabismus)