UMR
A UnitedHealthcare Company

Standard Plan

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)*: Deductible per family *(two or more members)*:	$500 $1,000	$500 $1,000	N/A N/A
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%	70%	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	
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? Apply deductible? Paid by Plan:	Yes Yes 80%	Yes Yes 80%	No

Orthotics

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

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 is covered 70% after deductible.			

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
Apply copay?	Yes	Yes	Yes
If yes, copay amount:*	$300	$300	$300
Paid by Plan:	100%	100%	100%

Hospital services in an Inpatient Setting

	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 copay?	No	No	No
Apply deductible?	Yes	Yes	Yes
Paid by Plan:	80%	70% 80% for **Emergency Admission Only**	70% **Emergency Admission Only**

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	Yes	No
Allow x-ray & ultrasounds *(Excludes outpatient imaging)* Apply deductible? Paid by Plan:	Yes No 100% after $25 copay per procedure	Yes No 70%	
Allow lab? Apply deductible? Paid by Plan:	Yes No 100% after $25 copay per procedure	Yes No 100% after $25 copay per procedure	
Allow outpatient charges for advanced imaging? *(PET/CT/MRI/MRA and nuclear medicine)* Apply deductible? Paid by Plan:	Yes Yes 80%	Yes Yes 70%	
Allow outpatient surgery? Apply deductible? Paid by Plan:	Yes Yes 80%	Yes Yes 70%	
Allow all other outpatient services? Apply deductible? Paid by Plan:	Yes Yes 80%	Yes Yes 70%	

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 copay?	Yes Yes $35	Yes Yes $60	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 copay? *If yes, copay amount?*	Yes Yes $35	Yes Yes $35	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 copay? *If yes, copay amount:*	Yes Yes **PCP:** $25 **Spec:** $60	Yes Yes **PCP:** $40 **Specialty not in HonorHealth:** $60 **Specialty in HonorHealth:** $125	No

Infertility

Summary of Benefits	
Does the Plan cover infertility? *If yes, what is covered under the Plan?* *(Other than diagnostic testing and treatment of the underlying medical condition)*	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. 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: **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? Apply copay? *If yes, copay amount:*	Yes Yes $25	Yes Yes $40	No
Is there a separate copay amount for specialists? If yes, *copay amount:* **Note:** 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)	Yes $60	Yes **Specialty not in HonorHealth:** $60 **Specialty in HonorHealth:** $125	
Office surgery *If yes,* Apply deductible? Paid by the plan	Yes Yes 80%	Yes Yes 70%	No

Office charges for x-ray and lab services *(Excludes outpatient imaging)* *If yes,* Apply deductible? Paid by Plan:	Yes No 100% $25 PCP/$60 SPEC	Yes No 100% After an additional PCP Or SPEC copay	No

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: $25 copay per visit; 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: $25 copay; 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?	Yes	Yes	No
Allow outpatient birthing centers?	Yes	Yes	
Allow home deliveries?	Yes	Yes	
Allow all elective abortions?	No	No	
Allow elective abortions if the life of the mother is in danger or as the result of incest or rape?	Yes	Yes	
Male Sterilization			
Allow sterilization for men?	Yes	Yes	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?	Yes	Yes	No
Apply copay?	No	No	
Paid by Plan:	100%	100%	

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?	Yes	Yes	
Paid by Plan:	80%	80%	
Maximum benefit per: No benefit maximum			

Manipulations

	Primary Network: HonorHealth/ICP	Secondary Network: UHC Choice Plus	Out of Network No coverage unless otherwise listed
Does the Plan cover manipulations?	Yes	Yes	No
Apply copay?	Yes	Yes	
If yes,copay amount:	$25	$25	
Apply deductible?	No	No	
Paid by Plan:	100%	100%	
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 Hospital and Office Therapy			
Apply copay?	Yes	Yes	
If yes, copay amount:*	$25	$25	

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 Hospital and Office Therapy			
Apply copay? *If yes, copay amount*:*	Yes $25	Yes $25	

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 $25 copay	Covered $25 copay	Excluded
Alternative/complimentary treatment			
• Holistic or homeopathic medicine Plan will cover services from a naturopathic provider only. 20 visits per calendar year, combined with manipulations and acupuncture.	Covered $25 copay	Covered $25 copay	Excluded
• Hypnosis	Excluded	Excluded	Excluded
• Other alternative treatment that is not accepted medical practice as determined by the Plan.	Excluded	Excluded	Excluded
Augmentation communication devices	Covered	Covered	Excluded
Biofeedback Secondary Network to be covered at Primary Network benefit level	Covered	Covered	Excluded
Blood pressure cuffs/monitors	Excluded	Excluded	Excluded
Breast reductions based on medical necessity	Covered	Covered	Excluded
Counseling *Note: Does not include home health or morbid obesity provision.*			
• Diabetic counseling	Covered	Covered	Excluded
• Nutritional counseling	Covered	Covered	Excluded
• Marriage counseling	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	Covered	Covered	Excluded
• Physical therapy	Covered	Covered	Excluded
• Speech therapy **Speech therapy for developmental delays requires an allowable medical diagnosis at visit one.*	Covered	Covered	Excluded
• Medical charges	Covered	Covered	Excluded

Experimental/investigational • Qualifying clinical trial	Excluded	Excluded	Excluded
• Life threatening condition exception	Excluded	Excluded	Excluded
Gender dysphoria	Covered	Covered Covered at Primary Network benefit	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	Covered	Covered	Excluded
• Palliative foot care	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)*	Covered	Covered	Excluded
• Supplies including feeding tubes, pumps, bags, and products.	Covered	Covered	Excluded
• Supplemental feedings, over-the-counter nutritional and electrolyte supplements.	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	Covered	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 *Note: Excluding services is not recommended due to possible ADA issues.* • 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	 Covered Covered Covered Covered	 Excluded Excluded Excluded Excluded
Sleep disorders	Covered	Covered	Excluded
Sleep studies	Covered	Covered	Excluded
Tobacco addiction	Covered	Covered	Excluded
Weight control *(morbid obesity)* *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.*	Covered	Covered	Excluded

• 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)*
	Covered	Excluded	Excluded

• Prescription medication needed for weight loss	Excluded under the medical plan	Excluded	Excluded
• Physician supervised weight loss programs at a medical facility	Excluded	Excluded	Excluded
• Diet supplements	Excluded	Excluded	Excluded
• Charges for diagnostic services	Covered	Covered	Excluded

• 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	Covered	Excluded
Wigs, toupees, hairpieces, etc. for cancer treatment or a medically necessary condition such as alopecia Areata?	Covered	Covered	Covered
Do you want all wig services paid in-network?		Yes	
Apply deductible?	Yes	Yes	Yes
Paid by Plan:	80%	80%	80%
Maximum benefit per: ☒ Calendar Year		$500	

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)