2016 Retiree Health Plan Comparison Chart – Under Age 65

BENEFIT	Choice Plus 80		Choice Plus 90		Choice Plus 100	
	In-Network	**Out-of-Network ***	**In-Network**	**Out-of-Network ***	**In-Network**	**Out-of-Network ***
Annual Deductible Individual Family	$400 per person	$600 per person	$200 per person	$600 per person	None	$600 per person
Coinsurance	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100%	60% after deductible
Annual Out-of-pocket ***Maximum Individual Family	$3,000 $6,000	$4,500 $9,000	$2,500 $5,000	$4,500 $9,000	$4,000 $8,000	$4,500 $9,000
Preventive Care	100%	Not covered	100%	Not covered	100%	Not covered
Physician Office Visits, including specialist	$30 copay	60% after deductible	$30 copay	60% after deductible	$30 copay	60% after deductible
Laboratory and Radiology Services, including services rendered in a physician's officer	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100% if non-hospital location $150 copay if hospital**	60% after deductible
Inpatient Hospital Care	80% after deductible	60% after deductible; *Pre-certification required*	90% after deductible	60% after deductible; *Pre-certification required*	$500 copay	60% after deductible; *Pre-certification required*
Outpatient Hospital Care	80% after deductible	60% after deductible; *Pre-certification required*	90% after deductible	60% after deductible; *Pre-certification required*	$150 copay (including lab and radiology)**	60% after deductible; *Pre-certification required*
Mental Health and Substance Abuse – Inpatient Care	80% after deductible	60% after deductible; *Pre-certification required*	90% after deductible	60% after deductible; *Pre-certification required*	$500 copay per admission	60% after deductible; *Pre-certification required*
Mental Health and Substance Abuse – Outpatient programs	$30 copay	70% after deductible for facility-based care including intensive outpatient programs; *Pre-certification required*	$30 copay	70% after deductible for facility-based care including intensive outpatient programs; *Pre-certification required*	$30 copay	70% after deductible for facility-based care including intensive outpatient programs; *Pre-certification required*
Mental Health and Substance Abuse – Outpatient counseling	$30 copay	70% after deductible	$30 copay	70% after deductible	$30 copay	70% after Deductible
Emergency Room	$150 copay (Waived if admitted)	$150 copay (Waived if admitted)	$150 copay (Waived if admitted)	$150 copay (Waived if admitted)	$150 copay (Waived if admitted)	$150 copay (Waived if admitted)

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BENEFIT	Choice Plus Plans	
Basic and Comprehensive Infertility Treatment	Unlimited benefit for diagnosis and basic medical treatment, including artificial insemination	
Advanced Infertility Treatment	$30,000 lifetime maximum for advanced treatments and Assisted Reproductive Technology including IVF, GIFT and ZIFT	
Prescription Drug coverage with Express Scripts	Retail (30-day supply) • Generic: $10 copay • Single-source brand: $25 copay • Multi-source brand: $45 copay	Mail-order (90-day supply) • Generic: $15 copay • Single-source brand: $50 copay • Multi-source brand: $90 copay

Vison Coverage

BENEFIT	Choice Plus Plans
Benefits Apply Both In-Network and Out-of Network	
Vision Care	(See Vision Care Network below for instructions on accessing the vision care network.) Child is defined as a member less than age 19. Provider might require payment in full at the time of service. The patient then submits a claim to UHC for reimbursement.
Routine Eye Exams	**Adult:** One exam every 12 months, with $10 copy **Children**: One exam every 12 months, with $10 copy
Lenses	**Adult:** Every 24 months, $20 Allowance for single lenses, $30 for bifocal, $40 for trifocal, and $75 for lenticular **Children**: Lenses covered in full every 12 months (more if medically necessary)
Frames	**Adult:** $30 allowance every 12 months **Children**: up to $100 covered in full every 12 months (more frequent if medically necessary). Cost above $100 covered at 60%
Contact Lenses	**Adult:** $75 allowance every 12 months **Children:** Purchase of a pair of contact lenses or 1 box of contact lenses per eye covered at 100% every 12 months

Important note: Most services require pre-certification. If you use a network provider, your participating network doctor or hospital generally takes care of the pre-certification process for you. However, it's always good to double-check that your provider has obtained the necessary authorizations from your health plan carrier. If you see a provider who is out-of-network, you are responsible for obtaining pre-certification.

* Out-of-network coinsurance reimbursement is based on 190% of the Medicare Maximum Allowable Charge (MAC).

** No copay for Lab and Radiology at certain designated NYP locations. List of NYP participating locations at http://hr.columbia.edu/forms-docs/search (under "NYP")

***Prescription plan drug copays count toward the medical plans annual in-network out-of-pocket maximums.

Vision Care Network: go to myUHC.com, select "Vision" from the "Benefits & Coverage" tab, then click "Vision Benefit Highlights" and you will be taken directly to the UnitedHealthcare Vision website. Then use the Provider Locator feature or call UnitedHealthcare Member Services (say "Benefits", then "vision") for assistance in locating a vision care provider.