MEDICAL: 2019 PLAN COMPARISON

IN-NETWORK SERVICES

Health Care Services	Base Plan Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Preventive Care*	100% coverage	100% coverage	100% coverage	100% coverage**
Eye and Hearing Exam (routine)	100% coverage	100% coverage	100% coverage	100% coverage
Physician***	$25 Primary/ $35 Specialty copay	$20 Primary/ $30 Specialty copay	$40 Primary/ $50 Specialty copay	90% coverage after deductible
All Walk-in/ Convenience Clinics and Virtual Care******	$15 copay	$15 copay	$20 copay	90% coverage after deductible
Outpatient MRI and CT Scan	$50 copay	$40 copay	$50 copay	90% coverage after deductible
Urgent Care: In-Network and Out-of-Network	$25 copay	$20 copay	$40 copay	90% coverage after deductible
Emergency Care: In-Network and Out-of-Network	$100 copay, waived if admitted	$100 copay, waived if admitted	$100 copay, waived if admitted	90% coverage after deductible
Outpatient Mental Health/ Substance Abuse	$25 copay	$20 copay	$40 copay	90% coverage after deductible
Chiropractic Care	$25 copay	$20 copay	$40 copay	90% coverage after deductible
Physical, Speech, and Occupational Therapy	$25 copay	$20 copay	$40 copay	90% coverage after deductible
Home Health Care	$25 copay	$20 copay	$40 copay	90% coverage after deductible

* Preventive care includes routine physical, hearing and eye exams; well child care; prenatal care; immunizations; and allergy injections.

**HSA guidelines do not view allergy injections as preventive; therefore, the deductible and coinsurance apply to this service.

*** Primary Care includes Family Medicine, Internal Medicine, Obstetrics/Gynecology, and Pediatrics.

**** Gopher Quick Clinic in the Twin Cities, WellCare in Duluth, and other walk-in/convenience care clinics; also applies to virtual care.

MEDICAL: 2019 PLAN COMPARISON

IN-NETWORK AND OUT-OF-NETWORK

Deductibles and Services	Base Plan Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
In-Network Deductible*	$100 per person/ $200 per family	$100 per person/ $200 per family	$200 per person/ $400 per family	Total in-network and out-of-network: Employee only: $1,500 Family: $3,000
Out-of-Network Deductible	$600 per person/ $1,200 per family	$600 per person/ $1,200 per family	$600 per person/ $1,200 per family	
Lab/X-Ray	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% coverage after deductible
Outpatient Surgery	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% coverage after deductible
In-Network Hospital (General and Mental Health/ Substance Abuse Care)	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% coverage after deductible
Ground and Air Ambulance to Nearest Facility	80% coverage	80% coverage	80% coverage	90% coverage after deductible
Prosthetics, Durable Medical Equipment	80% coverage, including hearing aids	80% coverage, including hearing aids	80% coverage, including hearing aids	90% coverage after deductible, including hearing aids
Out-of-Network Care	70% coinsurance after deductible is met, up to the annual out-of-pocket maximum	70% coinsurance after deductible is met, up to the annual out-of-pocket maximum	70% coinsurance after deductible is met, up to the annual out-of-pocket maximum	70% coinsurance after deductible is met, up to the annual out-of-pocket maximum

*In-network deductible applies to expenses without a copay, primarily in- and out-patient hospital, and lab/x-ray.

MEDICAL: 2019 PLAN COMPARISON

PRESCRIPTION DRUGS

The UPlan Pharmacy program is provided through Prime Therapeutics and Fairview Specialty Pharmacy. It is automatically provided to members in all UPlan medical options.
A prescription is dispensed as a 30-day supply (including insulin) in network pharmacies only.

Prescription Drug Categories	Base Plan Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Certain Preventive Medications Specified in the Affordable Care Act and Contraceptives in the Generic Plus Category	$0 copay	$0 copay	$0 copay	100%
Generic Plus (Tier 1) Drugs (includes all generic drugs and some low-cost brand drugs if there is no generic drug in a given therapeutic class)	$10 copay	$10 copay	$10 copay	Prescriptions are covered in the HSA and at 90% in medical plan after deductible
Formulary Brand Name (Tier 2) Drugs (includes all other formulary brand drugs)	$30 copay	$30 copay	$30 copay	Prescriptions are covered in the HSA and at 90% in medical plan after deductible
Non-formulary (Tier 3) Drugs (includes covered brand drugs not listed on formulary)	$75 copay	$75 copay	$75 copay	Prescriptions are covered in the HSA and at 90% in medical plan after deductible
Purchase of Brand Drug When Chemically Equivalent Generic is Available	Pay the **generic copay and difference in cost*** between the brand drug and the generic drug	Pay the **generic copay and difference in cost*** between the brand drug and the generic drug	Pay the **generic copay and difference in cost*** between the brand drug and the generic drug	Prescriptions are covered in the HSA and at 90% in medical plan after deductible**
Drugs Purchased by Mail Order	3-month supply available for two copays	3-month supply available for two copays	3-month supply available for two copays	90-day supply available at discount
Annual Out-of-Pocket Maximum (Rx only)	$750 per person/ $1,500 per family	$750 per person/ $1,500 per family	$750 per person/ $1,500 per family	No separate out-of-pocket maximum for prescriptions

* The difference in cost does not apply toward the annual out-of-pocket maximum.
** When in the coinsurance level, pay 10 percent coinsurance based on generic price in addition to difference in cost between the brand drug and the generic drug.

MEDICAL: 2019 PLAN COMPARISON

OTHER COVERAGE AND MAXIMUMS

Other Coverage and Maximums	Base Plan Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
Travel Benefit: In-Network Coverage	For students and other travelers if services are provided by United Healthcare Options PPO providers	For students and other travelers if services are provided by United Healthcare Options PPO providers	For out-of-area residents, students and other travelers if services are provided by United Healthcare Options PPO providers	For out-of-area residents, students and other travelers if services are provided by United Healthcare Options PPO providers
National Coverage	Available through emergency or out-of-network benefit only	Available through emergency or out-of-network benefit only	Available in-network through United Healthcare Options PPO network	Available in-network through United Healthcare Options PPO network
Annual Out-of-Pocket Maximum Total annual in-network and out-of-network	$2,500 per person/ $4,000 per family	$2,500 per person/ $4,000 per family	$2,500 per person/ $4,000 per family	$3,000 per person/ $6,000 per family (Note: Out-of-pocket maximums include the deductible)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited

HSA	UPlan Contributions*	Employee Contributions
Employee-only amount	$750	$2,750
Catch-up amount – Age 55 or over		$1,000
Family coverage amount (either tier)	$1,500	$5,500
Catch-up amount – Age 55 or over		$1,000

*UPlan contributions can be used to offset deductibles.

MEDICAL: 2019 UPLAN BIWEEKLY RATES

EMPLOYEE-ONLY

	Wellbeing Program Achievement Rates		Standard Rates		
Plans	**Employee**	**University**	**Employee**	**University**	**Total Cost**
Medica Elect/Essential: Twin Cities & Duluth Base Plan Medica Choice Regional: Greater Minnesota Base Plan	$20.78	$287.04	$40.01	$267.81	$307.82
Medica ACO Plan: Crookston area, Duluth area & parts of northeastern Minnesota, Rochester area, Twin Cities metro area	$10.07	$287.04	$29.30	$267.81	$297.11
Medica Choice National	$52.54	$287.04	$71.77	$267.81	$ 339.58
Medica HSA	$21.15	$287.04	$40.38	$267.81	$ 308.19

EMPLOYEE AND CHILDREN

	Wellbeing Program Achievement Rates		Standard Rates		
Plans	**Employee**	**University**	**Employee**	**University**	**Total Cost**
Medica Elect/Essential: Twin Cities & Duluth Base Plan Medica Choice Regional: Greater Minnesota Base Plan	$84.81	$448.76	$104.04	$429.53	$533.57
Medica ACO Plan: Crookston area, Duluth area & parts of northeastern Minnesota, Rochester area, Twin Cities metro area	$65.36	$448.76	$84.59	$429.53	$514.12
Medica Choice National	$138.75	$448.76	$157.98	$ 429.53	$587.51
Medica HSA	$85.87	$448.76	$105.10	$429.53	$534.63

EMPLOYEE AND SPOUSE WITH OR WITHOUT CHILDREN

	Wellbeing Program Achievement Rates		Standard Rates		
Plans	**Employee**	**University**	**Employee**	**University**	**Total Cost**
Medica Elect/Essential: Twin Cities & Duluth Base Plan Medica Choice Regional: Greater Minnesota Base Plan	$126.78	$671.35	$155.63	$642.50	$798.13
Medica ACO Plan: Crookston area, Duluth area & parts of northeastern Minnesota, Rochester area, Twin Cities metro area	$99.44	$671.35	$128.29	$642.50	$770.79
Medica Choice National	$209.00	$671.35	$237.85	$642.50	$880.35
Medica HSA	$127.99	$671.35	$156.84	$642.50	$799.34

If your appointment is 75% to 100% time, you will pay "Employee Cost" per pay period.
If your appointment is 50% to 74% time, you will pay "Total Cost" per pay period.

If you earn the required number of wellbeing points for a $500 or $750 reduction, your cost is shown in the **Wellbeing Program Achievement Rates** column. If you did not participate or earn the required number of wellbeing points, your cost is shown in the **Standard Rates** column.