

2019 STATE HEALTH PLAN COMPARISON

Medicare Primary Subscribers

PLAN DESIGN FEATURES	UNITEDHEALTHCARE® (UHC) GROUP MEDICARE ADVANTAGE BASE PLAN	UNITEDHEALTHCARE® (UHC) GROUP MEDICARE ADVANTAGE ENHANCED PLAN	70/30 PLAN*
Use of Network Providers	You can see any provider (in-network or out-of-network) that participates in Medicare and accepts Medicare assignment. Your copays or coinsurance stay the same.		You pay less when you use Blue Cross Blue Shield of North Carolina (Blue Cross NC) network providers.
Annual Deductible	\$0		Individual: \$1,080 in-network; \$2,160 out-of-network Family: \$3,240 in-network; \$6,480 out-of-network
Coinsurance	Most covered services require only a copay; however, some services require coinsurance (usually 20%).		In-network: 30% of eligible expenses after deductible Out-of-network: 50% of eligible expenses after deductible and the difference between the allowed amount and the charge
Annual Out-of-Pocket Maximum or Coinsurance Maximum	\$4,000 Individual No Family Maximum (An out-of-pocket maximum applies for this plan; it includes copays and coinsurance.)	\$3,300 Individual No Family Maximum (An out-of-pocket maximum applies for this plan; it includes copays and coinsurance.)	Individual: \$4,388 in-network; \$8,776 out-of-network Family: \$13,164 in-network; \$26,328 out-of-network (A coinsurance maximum applies for this plan; it does not include your payments toward your deductible or your copays.)
Affordable Care Act (ACA) Preventive Services	See plan materials for information about ACA covered services, as some require a copay.		In-network: \$40 for PCP; \$94 for Specialist
Office Visits	\$20 for PCP; \$40 for Specialist	\$15 for PCP; \$35 for Specialist	In-network: \$40 for PCP; \$94 for Specialist
Lab Services	\$40 copay	\$20 copay	If performed during PCP or Specialist office visit, no additional fee if in-network lab used

PCP: Primary Care Provider

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Urgent Care	\$50	\$40	\$100
Emergency Room (Copay waived w/admission or observation stay)	\$65		In-network: \$337 copay plus 30% coinsurance after deductible is met
Inpatient Hospital	Days 1-10: \$160/day Days 11+: \$0	Days 1-10: \$150/day Days 11+: \$0	In-network: \$337 copay plus 30% coinsurance after deductible is met
Outpatient Hospital	\$125	\$100	In-network: 30% coinsurance after deductible is met
Outpatient Surgery - Ambulatory Surgical Center	\$250		In-network: 30% coinsurance after deductible is met
Diagnostic (e.g., CT, MRI)	\$100		In-network: 30% coinsurance after deductible is met
Skilled Nursing Facility	Days 1-20: \$0 Days 21-100: \$50/day		In-network: 30% coinsurance after deductible is met
Chiropractic Visits	\$20		In-network: \$72
Durable Medical Equipment	20% coinsurance		In-network: 30% coinsurance after deductible is met
SilverSneakers® Fitness Program	Included		Not covered

* When enrolled in the 70/30 Plan, cost-sharing amounts between you and the State Health Plan will vary. Medicare pays benefits first. Then, the 70/30 Plan may help pay some of the costs that Medicare does not cover.

Pharmacy Benefits

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Pharmacy Out-of-Pocket Maximum	\$2,500 Individual No Family Maximum		\$3,360 Individual \$10,080 Family
RETAIL PURCHASE FROM AN IN-NETWORK PROVIDER			
Tier 1	\$10 copay per 31-day supply		\$16 copay per 30-day supply
Tier 2	\$40 copay per 31-day supply	\$35 copay per 31-day supply	\$47 copay per 30-day supply
Tier 3	\$64 copay per 31-day supply	\$50 copay per 31-day supply	\$74 copay per 30-day supply
Tier 4	25% coinsurance up to \$100 per 31-day supply		10% coinsurance up to \$100 per 30-day supply
Tier 5	N/A		25% coinsurance up to \$103 per 30-day supply
Tier 6	N/A		25% coinsurance up to \$133 per 30-day supply
Preferred Diabetic Testing Supplies	\$0*		\$10 copay per 30-day supply**
ACA Preventive Medications	See plan materials for information about ACA covered services, as some require a copay.		N/A
MAINTENANCE DRUGS FROM AN IN-NETWORK PROVIDER—UP TO A 90-DAY SUPPLY			
Tier 1	\$24 copay	\$20 copay	\$48 copay
Tier 2	\$80 copay	\$70 copay	\$141 copay
Tier 3	\$128 copay	\$100 copay	\$222 copay
Tier 4***	25% coinsurance up to \$300	25% coinsurance up to \$200	10% coinsurance up to \$300
Tier 5	N/A		25% coinsurance up to \$309
Tier 6	N/A		25% coinsurance up to \$399
ACA Preventive Medications	See plan materials for information about ACA covered services, as some require a copay.		N/A

*Non-preferred diabetic testing supplies are not covered.

** Preferred brand is the OneTouch Test Strips. Non-preferred diabetic testing supplies are not covered. Non-preferred diabetic testing supplies are considered a Tier 3 member copay (if approved).

*** Some specialty drugs are limited to a 30- or 31-day supply (depending on the plan).