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	Uniform Medical Plan (UMP Classic)	Group Health Classic	Group Health Value	Group Health CDHP	Uniform Medical Plan CDHP
Subscriber Only	\$ 82.00	\$ 101.00	\$ 52.00	\$ 26.00	\$ 27.00
Annual Premium	\$ 984.00	\$ 1,212.00	\$ 624.00	\$ 312.00	\$ 324.00
Subscriber & Spouse*	\$ 174.00	\$ 212.00	\$ 114.00	\$ 62.00	\$ 64.00
Annual Premium	\$ 2,088.00	\$ 2,544.00	\$ 1,368.00	\$ 744.00	\$ 768.00
Subscriber & Children	\$ 144.00	\$ 177.00	\$ 91.00	\$ 46.00	\$ 47.00
Annual Premium	\$ 1,728.00	\$ 2,124.00	\$ 1,092.00	\$ 552.00	\$ 564.00
Full Family	\$ 236.00	\$ 288.00	\$ 153.00	\$ 82.00	\$ 84.00
Annual Premium	\$ 2,832.00	\$ 3,456.00	\$ 1,836.00	\$ 984.00	\$ 1,008.00
Individual Monthly Contribution to HSA				\$ 58.34	\$ 58.34
Individual Annual Contribution				\$ 700.00	\$ 700.00
Family Monthly Contribution to HSA				\$ 116.67	\$ 116.67
Family Annual Contribution				\$ 1,400.00	\$ 1,400.00

Annual Costs	Uniform Medical Plan (UMP Classic)	Group Health Classic	Group Health Value	Group Health CDHP	Uniform Medical Plan CDHP
Deductible	\$250/person	\$250/person	\$350/person	\$1,400/individual	\$1,400/individual
	\$750/family	\$750/family	\$1,050/family	\$2,800/Subscriber with 1 or more dependents (must meet family deductible before plan pays benefits)	\$2,800/Subscriber with 1 or more dependents (must meet family deductible before plan pays benefits)
Out-of-pocket maximum	\$2,000/person	\$2,000/person	\$2,000/person	\$5,100/individual plan	\$4,200/individual plan
	\$4,000/family	\$4,000/family	\$4,000/family	\$10,200 family (must meet family out-of-pocket maximum before plan pays 100%)	\$8,400 family (must meet family out-of-pocket maximum before plan pays 100%)
Prescription drug deductible	\$100/person-\$300/family (Tier 2 and 3 drugs)	N/A	N/A	N/A	N/A
Benefit	Uniform Medical Plan (UMP Classic)	Group Health Classic	Group Health Value	Group Health CDHP	Uniform Medical Plan CDHP
Ambulance - Per trip, air	20%	20%	20%	10% (Extended network 30%)	20%
Ambulance - Per trip, ground	20%	20%	20%	10% (Extended network 30%)	20%
Diagnostic tests, laboratory, and x-rays	15%	\$0; MRI/CT/PET scan \$30	\$0; MRI/CT/PET scan \$40	10% (Extended network 30%)	15%
Durable medical equipment, supplies, and prostheses	15%	20%	20%	10% (Extended network 30%)	15%
Emergency room (Copay waived if admitted)	\$75 copay + 15%	\$150	\$200	10% (Extended network 30%)	15%

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Hearing - Hardware	Any amount over \$800 every 36 months after deductible has been met for hearing aid and rental/repair combined.	Any amount over \$800 every 36 months after deductible has been met for hearing aid and rental/repair combined.	Any amount over \$800 every 36 months after deductible has been met for hearing aid and rental/repair combined.	Any amount over \$800 every 36 months after deductible has been met for hearing aid and rental/repair combined.	Any amount over \$800 every 36 months after deductible has been met for hearing aid and rental/repair combined.
Hearing - Routine annual exam	\$0	\$15	\$20	10% (Extended network 30%)	15%
Home health	15%	\$0	\$0	10% (Extended network 30%)	15%
Hospital services - Inpatient	\$200/day; \$600 maximum/year per person + 15% professional fees	\$150/day; \$750 maximum/admission	\$200/day; \$1,000 maximum/admission	10% (Extended network 30%)	15%
Hospital services - Outpatient	15%	\$150	\$200	10% (Extended network 30%)	15%
Mental health care - Outpatient	Information unavailable, contact your plan	Information unavailable, contact your plan	Information unavailable, contact your plan	Information unavailable, contact your plan	Information unavailable, contact your plan
Obstetric care - Inpatient	Information unavailable, contact your plan	Information unavailable, contact your plan	Information unavailable, contact your plan	Information unavailable, contact your plan	Information unavailable, contact your plan
Obstetric care - Outpatient	Information unavailable, contact your plan	Information unavailable, contact your plan	Information unavailable, contact your plan	Information unavailable, contact your plan	Information unavailable, contact your plan
Office visit - Chemotherapy	15%	\$15	\$20	10% (Extended network 30%)	15%
Office visit - Mental health	15%	\$15	\$20	10% (Extended network 30%)	15%
Office visit - Primary care	15%	\$15	\$20	10% (Extended network 30%)	15%
Office visit - Radiation	15%	\$30	\$40	10% (Extended network 30%)	15%
Office visit - Specialist	15%	\$30	\$40	10% (Extended network 30%)	15%
Office visit - Urgent care	15%	\$15	\$20	10% (Extended network 30%)	15%
Physical, occupational and speech therapy (Per-visit cost for 60 visits/year combined)	15%	\$15	\$20	10% (Extended network 30%)	15%
Prescription drugs - Mail order (up to a 90-day supply) Value tier	5% (up to \$30/90-day supply)	\$10	\$10	\$10 (Extended network N/A)	15%*

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Prescription drugs - Mail order (up to a 90-day supply) Tier 1	10% (up to \$75/90-day supply)	\$40	\$40	\$40 (Extended network N/A)	15%
Prescription drugs - Mail order (up to a 90-day supply) Tier 2	30% (up to \$225/90-day supply)	\$80	\$80	\$80 (Extended network N/A)	15%
Prescription drugs - Mail order (up to a 90-day supply) Tier 3	50%* (Specialty drugs up to \$150; no limit for non-specialty)	50% up to \$750	50% up to \$750	50% up to \$750 (Extended network N/A)	15%*
Prescription drugs - Retail pharmacy (30-day supply) Value tier	5% (up to \$10/30-day supply)	\$5	\$5	\$5	15%*
Prescription drugs - Retail pharmacy (30-day supply) Tier 1	10% (up to \$25/30-day supply)	\$20	\$20	\$20	15%
Prescription drugs - Retail pharmacy (30-day supply) Tier 2	30% (up to \$75/30-day supply)	\$40	\$40	\$40	15%
Prescription drugs - Retail pharmacy (30-day supply) Tier 3	50%* (Specialty drugs up to \$150; no limit for non-specialty)	50% up to \$250	50% up to \$250	50% up to \$250	15%*
Preventive care	\$0; See certificate of coverage or check with plan for full list of services.	\$0; See certificate of coverage or check with plan for full list of services.	\$0; See certificate of coverage or check with plan for full list of services.	\$0 (Extended network 30%); See certificate of coverage or check with plan for full list of services.	\$0; See certificate of coverage or check with plan for full list of services.
Spinal manipulations	15%	\$15	\$20	10% (Extended network 30%)	15%
Vision care - Exam (annual)	\$0	\$15	\$20	10% (Extended network 30%)	\$0
Vision care - Glasses and contact lenses	Any amount over \$150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined.	Any amount over \$150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined.	Any amount over \$150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined.	Any amount over \$150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined.	Any amount over \$150 every 24 months (or two calendar years for UMP) for frames, lenses, contacts, and fitting fees combined.

* May also be subject to an ancillary charge if drug has an available generic equivalent.

UMP members who see an out-of-network provider will pay 40% of the allowed amount plus the amount the provider charged that was more than the allowed amount.

Group Health's Extended Network includes First Choice Health Network, Beech Street and its affiliated providers, and any other licensed provider in the U.S.