



# ALLtech Product Portfolio

This Plan Benefits Chart provides alternative health coverage options from UnitedHealthcare. These plans feature an array of costs, benefit designs and cost-sharing options, so they can be tailored to fit your employees' health care needs and preferences, as well as their budgets. And most importantly, all plans are supported by a national physician network and dedicated local customer service.



# Choice Plus Tech 1

Types of Coverage	Traditional 10/90% Plan WK-F		Traditional 15/80% Plan WK-I		Traditional with Ded 10/250/90% Plan WK-H	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Annual Deductible: Per Year *Family 2X Individual	\$0	\$300	\$0	\$500	\$250	\$250
Out-of-Pocket Maximum with Deductible *Family 2X Individual	\$1,500	\$2,300	\$2,000	\$4,000	\$1,250	\$2,250
Maximum Policy Benefit per Covered Person (combined Network/Non-Network)	\$5,000,000		\$5,000,000		\$5,000,000	
Non-Network Coinsurance	70%		60%		70%	
<b>Preventive Care</b>						
Office Visit	\$10	Not Covered	\$15	Not Covered	\$10	Not Covered
Lab, X-ray and preventive test	100%		100%		100%	
Vision Exams (Limited to one per year from a Network Provider)	\$10	Not Covered	\$15	Not Covered	\$10	Not Covered
<b>Emergency/Urgent Care</b>						
Ambulance Services - Emergency and Non-Emergency	90%		80%		90%	
Emergency Health Services - Outpatient	\$75		\$100		\$100	
Urgent Care Center Services	\$35		\$50		\$50	
<b>Professional Care/Diagnostics</b>						
Office Visit	\$10		\$15		\$10	
Professional Fees for Surgical and Medical Services	90%		80%		90%	
<b>Outpatient Surgery, Diagnostic and Therapeutic Services:</b>						
Surgery	90%		80%		90%	
Diagnostic Services	100%		100%		100%	
CT Scans, PET Scans, MRI and Nuclear Medicine	90%		80%		90%	
Outpatient Therapeutic Treatments	90%		80%		90%	
<b>Facility Care</b>						
Hospital - Inpatient Stay	90%		80%		90%	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Limited to 60 days per year)	90%		80%		90%	
Hospice Care	90%		80%		90%	
<b>Additional Benefits</b>						
Acupuncture Services (Limited to 10 visits per year)	\$10		\$15		\$10	
Durable Medical Equipment (Limited to \$10,000 per year)	90%		80%		90%	
Hearing Aids (Limited to \$5,000 per year)	90%		80%		90%	
Home Health Care (Limited to 130 home health care services per year)	90%		80%		90%	
Mental Health Services						
Inpatient and Intermediate	90%		80%		90%	
Outpatient	\$10		\$15		\$10	
Neurobiological Disorders - Autism Spectrum Disorder Services						
Inpatient and Intermediate	90%		80%		90%	
Outpatient	\$10		\$15		\$10	
Neurodevelopment Therapy	\$10		\$15		\$10	
Prosthetic Devices (Limited to \$10,000 per year)	90%		80%		90%	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**	\$10		\$15		\$10	
Substance Use Disorder Services						
Outpatient	\$10		\$15		\$10	
Inpatient and Intermediate	90%		80%		90%	
Transplantation Services (Limited to \$350,000 combined Network/Non-Network and 6-month Waiting Period)	90%		80%		90%	
Rx Plan Choices (must select one)	EM, F5, H9, K6, N7, NR, OL, OO, OP					

\*\* Limited to 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 24 visits of manipulative treatment; 20 visits of massage therapy; 20 visits of pulmonary rehabilitation; 36 visits of cardiac rehabilitation; and 30 visits of post-cochlear implant aural therapy Per Year.

**Choice Plus Tech 1 *continued***

Types of Coverage	Traditional with Ded 15/250/90% Plan WK-K		Traditional with Ded 15/250/80% Plan WK-J		Traditional with Ded 15/500/90% Plan WK-L		Traditional With Ded 10/500/80% Plan WK-G	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Annual Deductible: Per Year *Family 2X Individual	\$250	\$500	\$250	\$500	\$500	\$500	\$500	\$1,000
Out-of-Pocket Maximum with Deductible *Family 2X Individual	\$2,250	\$4,500	\$2,250	\$4,500	\$1,500	\$2,500	\$2,500	\$5,000
Maximum Policy Benefit per Covered Person (combined Network/Non-Network)	\$5,000,000		\$5,000,000		\$5,000,000		\$5,000,000	
Non-Network Coinsurance	70%		60%		70%		60%	
<b>Preventive Care</b>								
Office Visit	\$15	Not Covered	\$15	Not Covered	\$15	Not Covered	\$10	Not Covered
Lab, X-ray and preventive test	100%		100%		100%		100%	
Vision Exams (Limited to one per year from a Network Provider)	\$15	Not Covered	\$15	Not Covered	\$15	Not Covered	\$10	Not Covered
<b>Emergency/Urgent Care</b>								
Ambulance Services - Emergency and Non-Emergency	90%		80%		90%		80%	
Emergency Health Services - Outpatient	\$100		\$100		\$100		\$100	
Urgent Care Center Services	\$50		\$50		\$50		\$50	
<b>Professional Care/Diagnostics</b>								
Office Visit	\$15		\$15		\$15		\$10	
Professional Fees for Surgical and Medical Services	90%		80%		90%		80%	
<b>Outpatient Surgery, Diagnostic and Therapeutic Services:</b>								
Surgery	90%		80%		90%		80%	
Diagnostic Services	100%		100%		100%		100%	
CT Scans, PET Scans, MRI and Nuclear Medicine	90%		80%		90%		80%	
Outpatient Therapeutic Treatments	90%		80%		90%		80%	
<b>Facility Care</b>								
Hospital - Inpatient Stay	90%		80%		90%		80%	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Limited to 60 days per year)	90%		80%		90%		80%	
Hospice Care	90%		80%		90%		80%	
<b>Additional Benefits</b>								
Acupuncture Services (Limited to 10 visits per year)	\$15		\$15		\$15		\$10	
Durable Medical Equipment (Limited to \$10,000 per year)	90%		80%		90%		80%	
Hearing Aids (Limited to \$5,000 per year)	90%		80%		90%		80%	
Home Health Care (Limited to 130 home health care services per year)	90%		80%		90%		80%	
Mental Health Services								
Inpatient and Intermediate	90%		80%		90%		80%	
Outpatient	\$15		\$15		\$15		\$10	
Neurobiological Disorders - Autism Spectrum Disorder Services								
Inpatient and Intermediate	90%		80%		90%		80%	
Outpatient	\$15		\$15		\$15		\$10	
Neurodevelopment Therapy	\$15		\$15		\$15		\$10	
Prosthetic Devices (Limited to \$10,000 per year)	90%		80%		90%		80%	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**	\$15		\$15		\$15		\$10	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Limited to 60 days per year)								
Substance Use Disorder Services								
Outpatient	\$15		\$15		\$15		\$10	
Inpatient and Intermediate	90%		80%		90%		80%	
Transplantation Services (Limited to \$350,000 combined Network/Non-Network and 6-month Waiting Period)	90%		80%		90%		80%	
Rx Plan Choices (must select one)								

\*\* Limited to 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 24 visits of manipulative treatment; 20 visits of massage therapy; 20 visits of



## Choice Plus Tech 2

Types of Coverage	Traditional 15/90% Plan WK-R		Traditional 20/80% Plan WK-T		Traditional with Ded 15/250/90% Plan WK-S		Traditional with Ded 20/250/90% Plan WK-V	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Annual Deductible: Per Year *Family 3X Individual	\$0	\$300	\$0	\$500	\$250	\$250	\$250	\$500
Out-of-Pocket Maximum with Deductible *Family 3X Individual	\$2,000	\$4,000	\$2,500	\$5,000	\$2,500	\$5,000	\$3,000	\$6,000
Maximum Policy Benefit per Covered Person (combined Network/Non-Network)	\$5,000,000		\$5,000,000		\$5,000,000		\$5,000,000	
Non-Network Coinsurance	60%		50%		60%		60%	
<b>Preventive Care</b>								
Office Visit	\$15	Not Covered	\$20	Not Covered	\$15	Not Covered	\$20	Not Covered
Lab, X-ray and preventive test	100%		100%		100%		100%	
Vision Exams (Limited to one exam every 3 years from a Network Provider)	90%	Not Covered	80%	Not Covered	90%	Not Covered	90%	Not Covered
<b>Emergency/Urgent Care</b>								
Ambulance Services - Emergency and Non-Emergency	90%		80%		90%		90%	
Emergency Health Services - Outpatient	\$150 + 90%		\$150+ 80%		\$150+ 90%		\$150+ 90%	
Urgent Care Center Services	\$75		\$75		\$75		\$75	
<b>Professional Care/Diagnostics</b>								
Office Visit	\$15		\$20		\$15		\$20	
Professional Fees for Surgical and Medical Services	90%		80%		90%		90%	
<b>Outpatient Surgery, Diagnostic and Therapeutic Services:</b>								
Surgery	90%		80%		90%		90%	
Diagnostic Services	90%		80%		90%		90%	
CT Scans, PET Scans, MRI and Nuclear Medicine	90%		80%		90%		90%	
Outpatient Therapeutic Treatments	90%		80%		90%		90%	
<b>Facility Care</b>								
Hospital – Inpatient Stay (Inpatient per occurrence deductible of \$250)	90%		80%		90%		90%	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Limited to 60 days per year)	90%		80%		90%		90%	
Hospice Care	90%		80%		90%		90%	
<b>Additional Benefits</b>								
Acupuncture Services (Limited to 10 visits per year)	\$15		\$20		\$15		\$20	
Durable Medical Equipment (Limited to \$5,000 per year)	90%		80%		90%		90%	
Hearing Aids (Limited to \$5,000 per year)	90%		80%		90%		90%	
Home Health Care (Limited to 130 home health care services per year)	90%		80%		90%		90%	
<b>Mental Health Services</b>								
Inpatient and Intermediate	90%		80%		90%		90%	
Outpatient	\$15		\$20		\$15		\$20	
<b>Neurobiological Disorders - Autism Spectrum Disorder Services</b>								
Inpatient and Intermediate	90%		80%		90%		90%	
Outpatient	\$15		\$20		\$15		\$20	
Neurodevelopment Therapy	\$15		\$20		\$15		\$20	
Prosthetic Devices (Limited to \$5,000 per year)	90%		80%		90%		90%	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**	\$15		\$20		\$15		\$20	
<b>Substance Use Disorder Services</b>								
Outpatient	\$15		\$20		\$15		\$20	
Inpatient and Intermediate	90%		80%		90%		90%	
Transplantation Services (Limited to \$350,000 combined Network/Non-Network and 6-month Waiting Period)	90%		80%		90%		90%	
<b>Rx Plan Choices (must select one)</b>								

\*\* Limited to 30 visits combined for physical therapy, occupational therapy, speech therapy, massage therapy, pulmonary rehabilitation, cardiac rehabilitation and post-cochlear



## Choice Plus Tech 3

Types of Coverage	Traditional with Ded 20/500/80% Plan WO-T		Balanced 30/750/80% Plan WO-X		Balanced 30/1250/80% Plan WO-U		Balanced 30/1500/80% Plan WO-V	
	Network	Non- Network	Network	Non- Network	Network	Non- Network	Network	Non- Network
Annual Deductible: Per Year *Family 3X Individual	\$500	\$1,000	\$750	\$1,500	\$1,250	\$2,500	\$1,500	\$3,000
Out-of-Pocket Maximum with Deductible *Family 3X Individual	\$2,500	\$5,000	\$3,500	\$7,000	\$4,500	\$9,000	\$5,000	\$10,000
Maximum Policy Benefit per Covered Person (combined Network/Non-Network)	\$5,000,000		\$5,000,000		\$5,000,000		\$5,000,000	
Non-Network Coinsurance	50%		50%		50%		50%	
<b>Preventive Care</b>								
Office Visit	\$20	Not Covered	\$30	Not Covered	\$30	Not Covered	\$30	Not Covered
Lab, X-ray and preventive test	100%		100%		100%		100%	
Vision Exams (Limited to one exam every 3 years from a Network Provider)	80%	Not Covered	80%	Not Covered	80%	Not Covered	80%	Not Covered
<b>Emergency/Urgent Care</b>								
Ambulance Services - Emergency and Non-Emergency	80%		80%		80%		80%	
Emergency Health Services - Outpatient	\$150 + 80%		\$150 + 80%		\$150 + 80%		\$150 + 80%	
Urgent Care Center Services	\$75		\$75		\$75		\$75	
<b>Professional Care/Diagnostics</b>								
Office Visit	\$20		\$30		\$30		\$30	
Professional Fees for Surgical and Medical Services	80%		80%		80%		80%	
<b>Outpatient Surgery, Diagnostic and Therapeutic Services:</b>								
Surgery	80%		80%		80%		80%	
Diagnostic Services	80%		80%		80%		80%	
CT Scans, PET Scans, MRI and Nuclear Medicine	80%		80%		80%		80%	
Outpatient Therapeutic Treatments	80%		80%		80%		80%	
<b>Facility Care</b>								
Hospital – Inpatient Stay (Inpatient per occurrence deductible of \$250)	80%		80%		80%		80%	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Limited to 60 days per year)	80%		80%		80%		80%	
Hospice Care	80%		80%		80%		80%	
<b>Additional Benefits</b>								
Acupuncture Services (Limited to 10 visits per year)	\$20		\$30		\$30		\$30	
Durable Medical Equipment (Limited to \$5,000 per year)	80%		80%		80%		80%	
Hearing Aids (Limited to \$5,000 per year)	80%		80%		80%		80%	
Home Health Care (Limited to 130 home health care services per year)	80%		80%		80%		80%	
<b>Mental Health Services</b>								
Inpatient and Intermediate	80%		80%		80%		80%	
Outpatient	\$20		\$30		\$30		\$30	
<b>Neurobiological Disorders - Autism Spectrum Disorder Services</b>								
Inpatient and Intermediate	80%		80%		80%		80%	
Outpatient	\$20		\$30		\$30		\$30	
Neurodevelopment Therapy	\$20		\$30		\$30		\$30	
Prosthetic Devices (Limited to \$5,000 per year)	80%		80%		80%		80%	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**	\$20		\$30		\$30		\$30	
<b>Substance Use Disorder Services</b>								
Outpatient	\$20		\$30		\$30		\$30	
Inpatient and Intermediate	80%		80%		80%		80%	
Transplantation Services (Limited to \$350,000 combined Network/Non-Network and 6-month Waiting Period)	80%		80%		80%		80%	
Rx Plan Choices (must select one)	EM, F5, H9, K6, N7, NR, OL, OO, OP							

\*\* Limited to 30 visits combined for physical therapy, occupational therapy, speech therapy, massage therapy, pulmonary rehabilitation, cardiac rehabilitation and post-cochlear implant limited to 12 visits Per Year.

