

2026 Medical Plan Comparison Chart for Retired Officers 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	\$600 per person	\$850 per person	\$400 per person	\$850 per person	\$200 per person	\$850 per person
Coinsurance	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100% after deductible	60% after deductible
Annual Out-of-pocket ***Maximum Individual Family	\$3,750 \$7,500	\$5,250 \$10,500	\$3,250 \$6,500	\$5,250 \$10,500	\$4,750 \$9,500	\$5,250 \$10,500
Preventive Care	100%	60% after deductible	100%	60% after deductible	100%	60% after deductible
Physician Office Visits, including specialists	\$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 office	80% after deductible	60% after deductible	90% after deductible	60% after deductible	100% after deductible if non-hospital location \$150 copay if hospital**	60% after deductible
Inpatient Hospital Facility	80% after deductible	60% after deductible; <i>Precertification required</i>	90% after deductible	60% after deductible; <i>Precertification required</i>	\$500 copay per admission	60% after deductible; <i>Precertification required</i>
Inpatient Services	80% after deductible		90% after deductible		100% after deductible	
Outpatient Hospital Care	80% after deductible	60% after deductible; <i>Precertification required</i>	90% after deductible	60% after deductible; <i>Precertification required</i>	\$150 copay (including lab and radiology)**	60% after deductible; <i>Precertification required</i>
Mental Health and Substance Abuse – Inpatient Facility	80% after deductible	60% after deductible; <i>Precertification required</i>	90% after deductible	60% after deductible; <i>Precertification required</i>	\$500 copay per admission	60% after deductible; <i>Precertification required</i>
Inpatient Services	80% after deductible		90% after deductible		100% after deductible	
Mental Health and Substance Abuse – Outpatient programs	\$30 copay	70% after deductible for facility-based care, including intensive outpatient programs; <i>Precertification required</i>	\$30 copay	70% after deductible for facility-based care, including intensive outpatient programs; <i>Precertification required</i>	\$30 copay – but no copay for partial hospitalization/intensive outpatient treatment	70% after deductible for facility-based care, including intensive outpatient programs; <i>Precertification required</i>
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.				
Advanced Infertility Treatment	\$30,000 lifetime maximum for advanced treatments and Assisted Reproductive Technology, including IVF, GIFT and ZIFT				
Prescription Drug coverage with OptumRx	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Retail (30-day supply)</td> <td style="width: 50%; border: none;">Mail-order (90-day supply)</td> </tr> <tr> <td style="border: none;"> <ul style="list-style-type: none"> Tier I: \$10 copay Tier II: \$25 copay Tier III: \$45 copay </td> <td style="border: none;"> <ul style="list-style-type: none"> Tier I: \$15 copay Tier II: \$50 copay Tier III: \$90 copay </td> </tr> </table>	Retail (30-day supply)	Mail-order (90-day supply)	<ul style="list-style-type: none"> Tier I: \$10 copay Tier II: \$25 copay Tier III: \$45 copay 	<ul style="list-style-type: none"> Tier I: \$15 copay Tier II: \$50 copay Tier III: \$90 copay
Retail (30-day supply)	Mail-order (90-day supply)				
<ul style="list-style-type: none"> Tier I: \$10 copay Tier II: \$25 copay Tier III: \$45 copay 	<ul style="list-style-type: none"> Tier I: \$15 copay Tier II: \$50 copay Tier III: \$90 copay 				
Eligible specialty medications will be processed through PillarRX with a 30% coinsurance, offset by the manufacturer discount. You will be notified in advance if you need to enroll.					

*Eligible expenses are determined in accordance with the Claims Administrator's reimbursement policy as described in the Summary Plan Description.

**No copay for Lab and Radiology at designated New York Presbyterian (NYP) locations. Go to humanresources.columbia.edu/documents and search "New York-Presbyterian (NYP) Outpatient Laboratory Locations" for the list.

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

Important note: Most services require precertification. If you use a network provider, your participating network physician or hospital generally takes care of the precertification 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.

Basic Vision 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 copay Children: One exam every 12 months, with \$10 copay
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

*Available for either frames and lenses or contact lenses.

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 help locating a vision care provider.