

 DIESEL USA GROUP® - INCORPORATED -	United Healthcare Medical Plan Comparison Plan Year Effective January 1, 2016						
	PLAN NAME	PLAN 1 - BUY UP		PLAN 2 - CORE		PLAN 3 - HDHP (HSA)	
	MEDICAL SERVICES	IN NETWORK BENEFITS		IN NETWORK BENEFITS		IN NETWORK BENEFITS	
INDIVIDUAL ANNUAL DEDUCTIBLE	\$750		\$1,000		\$3,000		
FAMILY ANNUAL DEDUCTIBLE	\$1,500		\$2,000		\$6,000		
INDIVIDUAL OUT-OF-POCKET MAXIMUM	\$2,750 <i>Includes deductible, coinsurance, medical and prescription copays</i>		\$4,000 <i>Includes deductible, coinsurance, medical and prescription copays</i>		\$4,500 <i>Includes deductible and prescription copays</i>		
FAMILY OUT-OF-POCKET MAXIMUM	\$5,500 <i>Includes deductible, coinsurance, medical and prescription copays</i>		\$8,000 <i>Includes deductible, coinsurance, medical and prescription copays</i>		\$9,000 <i>Includes deductible and prescription copays</i>		
INPATIENT HOSPITAL SERVICES	20% after deductible		20% after deductible		0% after deductible		
OUTPATIENT HOSPITAL SERVICES	20% after deductible		20% after deductible		0% after deductible		
EMERGENCY ROOM FACILITY	\$150 copay		\$150 copay		0% after deductible		
PRIMARY CARE PHYSICIAN OFFICE VISIT	\$30 copay		\$35 copay		0% after deductible		
SPECIALIST OFFICE VISIT	\$50 copay		\$60 copay		0% after deductible		
PREVENTIVE / WELLNESS CARE	Covered in full		Covered in full		Covered in full		
URGENT CARE FACILITY	\$75 copay		\$75 copay		0% after deductible		
PRESCRIPTION DRUGS (30 DAY SUPPLY) MAILORDER (90 DAY SUPPLY)	\$10 / \$35 / \$60 / \$100 2.5 times copay		\$10 / \$35 / \$60 / \$100 2.5 times copay		Deductible then: \$10 / \$30 / \$50 2.5 times copay		
EMPLOYEE COST PER PAY PERIOD (26 PERIODS)	PLAN 1 - BUY UP		PLAN 2 - CORE		PLAN 3 - HDHP (HSA)		
	With Wellness Incentive*	Without Wellness Incentive*	With Wellness Incentive*	Without Wellness Incentive*	With Wellness Incentive*	Without Wellness Incentive*	
Employee	\$58.97	\$73.97	\$48.21	\$63.21	\$19.27	\$34.27	
Employee/Spouse	\$123.83	\$138.83	\$101.25	\$116.25	\$40.47	\$55.47	
Employee/Child(ren)	\$106.14	\$121.14	\$86.79	\$101.79	\$34.68	\$49.68	
Family	\$188.70	\$203.70	\$154.29	\$169.29	\$61.66	\$76.66	
Note: This is a general summary of benefits. Please consult the certificate of coverage for complete details of the plan. If there is a discrepancy between this summary and the actual certificate will prevail.							