UnitedHealthcare PPO Medical Plan
Effective 1/1/2015

Benefits	Inside Network	Out-of-Network
Plan Deductible—Per Calendar Year (PCY)	Individual deductible: $325 Family deductible: $650	Individual deductible: $425 Family deductible: $850
Plan Co-insurance	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Out-Of-Pocket Limit (PCY) (RX excluded)	Individual out-of-pocket limit: $1,350 Family out-of-pocket limit: $2,700	Individual out-of-pocket limit: $3,500 Family out-of-pocket limit: $7,000
Lifetime Maximum	No lifetime maximum.	No lifetime maximum.
Office Visit/Urgent Care	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Outpatient Services	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Hospital Services Inpatient And Outpatient	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Prescription Drugs Covered through Express Scripts, Inc.	**Retail: (for a 30-day supply)** Generic: $10 Brand name preferred: $35 Brand name non-preferred: $50 **Mail Order: (for a 90-day supply)** Generic: $20 Brand name preferred: $70 Brand name non-preferred: $100 **Specialty Drug:** 20% co-insurance, at a minimum of $65 (or actual cost of the drug if less), maximum of $150. **Out-of-Pocket Limit:** $1,750	Contact Express Scripts, Inc. for reimbursement details
Acupuncture	Limited to 20 visits per calendar year. Deductible and co-insurance apply.	Visit limit shared with in-network. Deductible and co-insurance apply.
Ambulance (True Emergency)	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Chemical Dependency	See Summary of Benefits and Coverage.	See Summary of Benefits and Coverage.
Chiropractic Services	Limited to 20 visits every calendar year. Deductible and co-insurance apply.	Visit limit shared with in-network. Deductible and co-insurance apply.
Devices, Medical Equipment DME), and Supplies (Prosthetics)	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Diagnostic Laboratory and X-Ray Services (Outpatient)	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Emergency Services	$125 co-pay per visit. Deductible and co-insurance apply.	$125 co-pay per visit. In-network deductible and in-network co-insurance apply.

UnitedHealthcare PPO Medical Plan (cont'd)
Effective 1/1/2015

Benefits	Inside Network	Out-of-Network
Hearing Exam	Limited to one exam every 12 months. Deductible and co-insurance apply.	Visit limit shared with in-network. Deductible and co-insurance apply.
Hearing Aids	Limited to $300 every 36 months. Deductible and co-insurance apply.	Dollar limit shared with in-network. Deductible and co-insurance apply.
Home Health	Limited to 40 visits per calendar year. Deductible and co-insurance apply.	Visit limit shared with in-network. Deductible and co-insurance apply.
Infertility Services	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Maternity Services	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Mental Health	See Summary of Benefits and Coverage.	See Summary of Benefits and Coverage.
Naturopathy Services	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Obesity Surgery	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Organ Transplants	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Preventive Care	Covered at 100%. Not subject to deductible.	Deductible and co-insurance apply.
Rehabilitation Services (Occupational, Speech and Physical Therapies)	Limits per calendar year: Physical, Speech, Occupational - 30 visits; Cardiac - 20 visits; Pulmonary - 20 visits.	Visit limit shared with in-network. Deductible and co-insurance apply.
Skilled Nursing	Limited to 60 days per calendar year. Deductible and co-insurance apply.	Days limit shared with in-network. Deductible and co-insurance apply.
Sterilization (Vasectomy, Tubal Ligation)	Deductible and co-insurance apply.	Deductible and co-insurance apply.
Vision Care	**Annual Exam:** $10 co-pay **Optical Hardware:** Lenses covered every 12 months: $10 co-pay. Frames every 24 months.	**Annual Exam:** 85% of contracted charges. Maximum reimbursement in a calendar year is $165 for exam and hardware combined. **Optical Hardware:** Frames and lenses every other year up to $165 total, including exam.