

UNITEDHEALTHCARE PPO MEDICAL

PLAN EFFECTIVE 1/1/2019

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	\$150 co-pay per visit. Deductible and co-insurance apply.	\$150 co-pay per visit. In-network deductible and in-network co-insurance apply.

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(CONT'D) EFFECTIVE 1/1/2019

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.	Benefit 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.
Hospice Services	Deductible and co-insurance apply. Limited to 15 visits per family member. Inpatient pre-notification is required or benefit reduces to 50% of eligible expenses.	Deductible and co-insurance apply. Visit limit shared with in-network. Inpatient pre-notification is required or benefit reduces to 50% of eligible expenses.
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.	Day 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.