EPC BENEFIT PLAN SUMMARY – UNITED HEALTHCARE Choice Plus PPO

District: Brookville Local Schools – Core Plan

Dependents: Spouse and unmarried children to age 19. From age 19 to 24 (end of calendar year): fulltime student or unemployed IRS qualified dependent.

More information: UHC Customer Service: 1 866-844-4864 or www.MyUHC.com

For Nurseline medical information or counseling contact Care24 at 1-877 365-7950

This is UHC's **Choice Plus P**referred **P**rovider **O**rganization plan with a Network of medical providers who have contracts with UHC. You will pay less out of pocket using Network providers.

Plan Features	Network	Non-Network [3]
■ Deductible (Single / Family Max) [1]	$100 / 200	$300 /600
■ Out Of Pocket Max (Single / Family Max) [2]	$1000 / 2000	$2000 / 4000
■ Lifetime Maximum	Unlimited	$ 1 Million
Covered Services		
Physician Office Visits	$20 Copay Per Visit	30% of Eligible Expenses
■ Diagnostic Lab & X-Ray		30% of Eligible Expenses
■ Well Child Care/Immunizations		$500 to age 1; $150 ages 1 – 9
■ Routine Physical Exams & Preventive Care		Not Covered
■ Routine Vision & Hearing Exams (Limited to 1 every 12 months)		Not Covered
■ Mammograms	No copay if no office charge	30% of Eligible Expenses
Outpatient Diagnostic Services ■ Diagnostic, Laboratory And X-Ray	10% of Eligible Expenses	30% of Eligible Expenses
Outpatient Surgery ■ Outpatient Surgical Center	10% of Eligible Expenses	30% of Eligible Expenses
Outpatient Rehabilitation (In office)		
■ Physical Therapy	$20 Copay	30% of Eligible Expenses
■ Occupational Therapy	$20 Copay	30% of Eligible Expenses
■ Speech Therapy (50 visits total PT, OT, SpT / year)	$20 Copay	30% of Eligible Expenses
■ Spinal Manipulation (Max 24 visits per year)	$20 Copay	30% of Eligible Expenses
Inpatient Hospital Services ■ Room And Board ■ Misc. Charges	$250 copay	30% of Eligible Expenses *
Inpatient Professional Fees ■ Surgery ■ In patient Physician Care	10% of Eligible Expenses	30% of Eligible Expenses
Maternity Care ■ Physician Prenatal And Postnatal Care	10% of Eligible Expenses	30% of Eligible Expenses
Emergency Care		
■ Hospital Emergency Room Care (Copay Waived If Admitted)	$75 Copay	$75 Copay
■ Urgent Care Facilities	$35 Copay	30% of Eligible Expenses
■ Ambulance Services	10% of Eligible Expenses	10% of Eligible Expenses

Medical Equipment, Supplies & Appliances	20% of Eligible Expenses *	50% of Eligible Expenses *
Home Health Care (Max 8 hours of services per 24 hour period)	10% of Eligible Expenses *	30% of Eligible Expenses *
Hospice Services (Max 180 days)	10% of Eligible Expenses *	30% of Eligible Expenses *
Skilled Nursing Facility/Extended Care Facility Services (Max 300 Days Per Year)	10% of Eligible Expenses *	30% of Eligible Expenses *
Transplant Benefits Through United Resource Networks	20% of Eligible Expenses *	Not covered
Mental Health/Substance Abuse * [4] **Inpatient** 30 days per year (Call 1 800 860 1123 for MH/CD authorization)	20% of Eligible Expenses *	30% of Eligible Expenses *
Outpatient	$20 Office Visit Copay * 50 visits per year	30% of Eligible Expenses – 30 visits per year

Prescription Drug Services (Out-of-Network benefits apply when you use a non-participating pharmacy)		
Retail Pharmacy		
■ Tier 1	$10 Copay	UHC payment same as network
■ Tier 2	25% (Min. $15, Max $35 Copay)	Member pays copays +
■ Tier 3	$45 Copay	Difference in Rx cost
Mail Order Pharmacy	2 copays; 3 month supply	

Drug Tier Definitions

Tier 1 – Mostly Generics that are on the Preferred Drug List
Tier 2 – Mostly Brand name drugs that are on the Preferred Drug List
Tier 3 – Drugs that are not on the Preferred Drug List
Note: Generic and Brand name drugs that are on the Preferred Drug List may move up or down tiers due to changes in comparative price and effectiveness. For Preferred Drug List see www.MyUHC.com

* Prior authorization is required – call Customer Service.

The most recent plan changes were effective: October 1, 2005

More details: This is a brief summary of benefits. For plan details and **exclusions** which may apply, please refer to your Certificate of Coverage or call Customer Service. In the event of a conflict between this summary and the Group Contract, the terms of the Group Contract will prevail. Additional information can also be found on the **UHC** page of this website.

[1] **Deductible**: The deductible applies to non co-pay expenses that are paid at a percentage less than 100%, unless noted otherwise. . The family deductible caps deductible expenses for a family. No more than the single deductible amount will be applied to an individual.

[2] **Out of Pocket Maximum**: This caps the amount of covered expenses which you are liable to pay during a calendar year – your Maximum Out of Pocket expenses. The Out of Pocket max includes your coinsurance - the amount you pay as a percentage of the charge. It does not include deductibles, copays such as office visit , hospital and Rx copays and any Mental Health expenses. Any Non-Network expenses that are over UHC's Maximum Allowable Charge are not included in the Out of Pocket max. Also, any expenses that are not covered by the plan are not included.

When you reach your Out of Pocket maximum during the calendar year, additional covered expenses that would be paid at a percentage less than 100% will be paid at 100% for the remainder of the year.

Network and Non-Network deductibles, copayments and out-of-pocket maximums are separate and do not accumulate toward each other.

Network Providers: These are medical providers who have a contract with UHC. They bill directly to UHC, and you should not be charged more than your share of the cost according to the Network column. UHC's network is national. For a current list of UHC providers refer to www.myUHC.com. For expenses paid at less than 100%, the percentage of payment is based on the UHC discounted charge.

[3] **Non-Network Providers**: Non Network providers do not have contracts with UHC and can bill you according to their own fee schedule which may exceed UHC's Maximum Allowable Charge (MAC). The percentage that UHC pays Non-Network is based on the MAC, not the amount billed by the provider. Non-Network providers can bill you for the amount their fee exceeds the MAC. Many non-network expenses require prior authorization. Contact Customer Service prior to incurring a major expense.

[4] **Mental Health**: Mental health / substance abuse must be authorized by the mental health administrator for services to be covered at the highest level. Call 1 800-860-1123 for authorized referral.

For more information on how to get the most from your United Healthcare coverage, please refer to the UHC page of this website.

EPC BENEFIT PLAN SUMMARY – UNITED HEALTHCARE Choice Plus PPO

District: Brookville Local Schools – High Option

Dependents: Spouse and unmarried children to age 19. From age 19 to 24 (end of calendar year): fulltime student or unemployed IRS qualified dependent.

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This is UHC's **Choice Plus P**referred **P**rovider **O**rganization plan with a Network of medical providers who have contracts with UHC. You will pay less out of pocket using Network providers.

Plan Features	Network	Non-Network [3]
■ Deductible (Single / Family Max) [1]	N/A	$200 / $4300
■ Out Of Pocket Max (Single / Family Max) [2]	$650 / $1300	$1000 / $2000
■ Lifetime Maximum	Unlimited	$ 1 Million
Covered Services		
Physician Office Visits	$15 Copay Per Visit	20% of Eligible Expenses
■ Diagnostic Lab & X-Ray		20% of Eligible Expenses
■ Well Child Care/Immunizations		$500 to age 1; $150 ages 1 – 9
■ Routine Physical Exams & Preventive Care		Not Covered
■ Routine Vision & Hearing Exams (Limited to 1 every 12 months)		Not Covered
■ Mammograms	No copay if no office charge	20% of Eligible Expenses
Outpatient Diagnostic Services	100%	20% of Eligible Expenses
■ Diagnostic, Laboratory And X-Ray		
Outpatient Surgery	100%	20% of Eligible Expenses
■ Outpatient Surgical Center		
Outpatient Rehabilitation (In office)		
■ Physical Therapy	$15 Copay	20% of Eligible Expenses
■ Occupational Therapy	$15 Copay	20% of Eligible Expenses
■ Speech Therapy	$15 Copay	20% of Eligible Expenses
(50 visits total PT, OT, SpT / year)		
■ Spinal Manipulation	$15 Copay	20% of Eligible Expenses
(Max 24 visits per year)		
Inpatient Hospital Services	100%	20% of Eligible Expenses *
■ Room And Board		
■ Misc. Charges		
Inpatient Professional Fees	100%	20% of Eligible Expenses
■ Surgery		
■ In patient Physician Care		
Maternity Care	100%	20% of Eligible Expenses
■ Physician Prenatal And Postnatal Care		
Emergency Care		
■ Hospital Emergency Room Care (Copay Waived If Admitted)	$75 Copay	$75 Copay
■ Urgent Care Facilities	$35 Copay	20% of Eligible Expenses
■ Ambulance Services	100%	100%

Medical Equipment, Supplies & Appliances	20% of Eligible Expenses *	50% of Eligible Expenses *
Home Health Care (Max 8 hours of services per 24 hour period)	100% *	20% of Eligible Expenses *
Hospice Services (Max 180 days)	100% *	20% of Eligible Expenses *
Skilled Nursing Facility/Extended Care Facility Services (Max 300 Days Per Year)	100% *	20% of Eligible Expenses *
Transplant Benefits Through United Resource Networks	20% of Eligible Expenses *	Not covered
Mental Health/Substance Abuse * [4] **Inpatient** 30 days per year (Call 1 800 860 1123 for MH/CD authorization) **Outpatient**	20% of Eligible Expenses * $15 Office Visit Copay * 50 visits per year	20% of Eligible Expenses * 20% of Eligible Expenses – 30 visits per year

Prescription Drug Services (Out-of-Network benefits apply when you use a non-participating pharmacy)		
Retail Pharmacy ■ Tier 1 ■ Tier 2 ■ Tier 3 **Mail Order Pharmacy**	 $ 5 Copay 25% (Min. $10, Max $30 Copay) $40 Copay 2 copays; 3 month supply	 UHC payment same as network Member pays copays + Difference in Rx cost

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Tier 1 – Mostly Generics that are on the Preferred Drug List
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