

# EPC BENEFIT PLAN SUMMARY – UNITED HEALTHCARE Choice Plus PPO



## District: Greenon Local Schools – Classified Employees

**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](http://www.MyUHC.com)

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

This is UHC's **Choice Plus Preferred Provider Organization** 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 <sup>3</sup>
<ul style="list-style-type: none"> <li>■ Deductible (Single / Family Max) <sup>1</sup></li> <li>■ Out Of Pocket Max (Single / Family Max) <sup>2</sup></li> <li>■ Lifetime Maximum</li> </ul>	<p>N/A</p> <p>\$650 / \$1300</p> <p>Unlimited</p>	<p>\$200 / 400</p> <p>\$850 / \$1700</p> <p>\$ 1 Million</p>
<b>Covered Services</b>		
<p><b>Physician Office Visits</b></p> <ul style="list-style-type: none"> <li>■ Diagnostic Lab &amp; X-Ray</li> <li>■ Well Child Care/Immunizations</li> <li>■ Routine Physical Exams &amp; Preventive Care</li> <li>■ Routine Vision &amp; Hearing Exams (Limited to 1 every 12 months)</li> </ul>	<p>\$15 Copay Per Visit</p>	<p>20% of Eligible Expenses</p> <p>20% of Eligible Expenses</p> <p>\$500 to age 1; \$150 ages 1 – 9</p> <p>Not Covered</p> <p>Not Covered</p>
<ul style="list-style-type: none"> <li>■ Mammograms</li> </ul>	<p>No copay if no office charge</p>	<p>20% of Eligible Expenses</p>
<p><b>Outpatient Diagnostic Services</b></p> <ul style="list-style-type: none"> <li>■ Diagnostic, Laboratory And X-Ray</li> </ul>	<p>100%</p>	<p>20% of Eligible Expenses</p>
<p><b>Outpatient Surgery</b></p> <ul style="list-style-type: none"> <li>■ Outpatient Surgical Center</li> </ul>	<p>100%</p>	<p>20% of Eligible Expenses</p>
<p><b>Outpatient Rehabilitation (In office)</b></p> <ul style="list-style-type: none"> <li>■ Physical Therapy</li> <li>■ Occupational Therapy</li> <li>■ Speech Therapy</li> <li>(50 visits total PT, OT, SpT / year)</li> <li>■ Spinal Manipulation</li> <li>(Max 24 visits per year)</li> </ul>	<p>\$15 Copay</p> <p>\$15 Copay</p> <p>\$15 Copay</p> <p>\$15 Copay</p>	<p>20% of Eligible Expenses</p> <p>20% of Eligible Expenses</p> <p>20% of Eligible Expenses</p> <p>20% of Eligible Expenses</p>
<p><b>Inpatient Hospital Services</b></p> <ul style="list-style-type: none"> <li>■ Room And Board</li> <li>■ Misc. Charges</li> </ul>	<p>\$250 Copay</p>	<p>20% of Eligible Expenses *</p>
<p><b>Inpatient Professional Fees</b></p> <ul style="list-style-type: none"> <li>■ Surgery</li> <li>■ In patient Physician Care</li> </ul>	<p>100%</p>	<p>20% of Eligible Expenses</p>
<p><b>Maternity Care</b></p> <ul style="list-style-type: none"> <li>■ Physician Prenatal And Postnatal Care</li> </ul>	<p>100%</p>	<p>20% of Eligible Expenses</p>
<p><b>Emergency Care</b></p> <ul style="list-style-type: none"> <li>■ Hospital Emergency Room Care (Copay Waived If Admitted)</li> <li>■ Urgent Care Facilities</li> <li>■ Ambulance Services</li> </ul>	<p>\$75 Copay</p> <p>\$35 Copay</p> <p>100%</p>	<p>\$75 Copay</p> <p>20% of Eligible Expenses</p> <p>100%</p>

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

<b>Prescription Drug Services (Out-of-Network benefits apply when you use a non-participating pharmacy)</b>		
<b>Retail Pharmacy</b> <ul style="list-style-type: none"> <li>■ Tier 1</li> <li>■ Tier 2</li> <li>■ Tier 3</li> </ul> <b>Mail Order Pharmacy</b>	\$10 Copay 25% (Min. \$15, Max \$35 Copay) \$45 Copay 2 copays; 3 month supply	UHC payment same as network Member pays copays + Difference in Rx cost
<b>Drug Tier Definitions</b>		
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 <a href="http://www.MyUHC.com">www.MyUHC.com</a>		

\* 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.

<sup>1</sup> **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.

<sup>2</sup> **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](http://www.myUHC.com). For expenses paid at less than 100%, the percentage of payment is based on the UHC discounted charge.

<sup>3</sup> **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.

<sup>4</sup> **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.

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<b>Plan Features</b>	<b>Network</b>	<b>Non-Network <sup>3</sup></b>
<ul style="list-style-type: none"> <li>■ Deductible (Single / Family Max) <sup>1</sup></li> <li>■ Out Of Pocket Max (Single / Family Max) <sup>2</sup></li> <li>■ Lifetime Maximum</li> </ul>	<p>\$100 / \$200</p> <p>\$1,000 / \$2,000</p> <p>Unlimited</p>	<p>\$200 / \$400</p> <p>\$2,000 / \$4,000</p> <p>\$ 1 Million</p>
<b>Covered Services</b>		
<p><b>Physician Office Visits</b></p> <ul style="list-style-type: none"> <li>■ Diagnostic Lab &amp; X-Ray</li> <li>■ Well Child Care/Immunizations</li> <li>■ Routine Physical Exams &amp; Preventive Care</li> <li>■ Routine Vision &amp; Hearing Exams (Limited to 1 every 12 months)</li> </ul>	<p>\$15 Copay Per Visit</p>	<p>30% of Eligible Expenses</p> <p>30% of Eligible Expenses</p> <p>\$500 to age 1; \$150 ages 1 – 9</p> <p>Not Covered</p> <p>Not Covered</p>
<ul style="list-style-type: none"> <li>■ Mammograms</li> </ul>	<p>No copay if no office charge</p>	<p>30% of Eligible Expenses</p>
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<p><b>Outpatient Rehabilitation (In office)</b></p> <ul style="list-style-type: none"> <li>■ Physical Therapy</li> <li>■ Occupational Therapy</li> <li>■ Speech Therapy</li> <li>(90 visits total PT, OT, SpT / year)</li> <li>■ Spinal Manipulation</li> <li>(Max 24 visits per year)</li> </ul>	<p>\$15 Copay</p> <p>\$15 Copay</p> <p>\$15 Copay</p> <p>\$15 Copay</p>	<p>30% of Eligible Expenses</p> <p>30% of Eligible Expenses</p> <p>30% of Eligible Expenses</p> <p>30% of Eligible Expenses</p>
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<p><b>Inpatient Professional Fees</b></p> <ul style="list-style-type: none"> <li>■ Surgery</li> <li>■ In patient Physician Care</li> </ul>	<p>10% of Eligible Expenses</p>	<p>30% of Eligible Expenses</p>
<p><b>Maternity Care</b></p> <ul style="list-style-type: none"> <li>■ Physician Prenatal And Postnatal Care</li> </ul>	<p>10% of Eligible Expenses</p>	<p>30% of Eligible Expenses</p>
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<b>Medical Equipment, Supplies &amp; Appliances</b>	20% of Eligible Expenses *	50% of Eligible Expenses *
<b>Home Health Care</b> (Max 8 hours of services per 24 hour period)	10% of Eligible Expenses *	30% of Eligible Expenses *
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<b>Drug Tier Definitions</b>		
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