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2022 UHC PPO 2 Plan Summary

Benefit	In-Network	Out-of-Network
Deductible		
Individual	$1,250	$2,500
Family	$2,500	$5,000
Co-Payments		
Office Visit	$30	Deductibles & Coinsurance Apply
Specialist Visits	$50	Deductibles & Coinsurance Apply
Urgent Care Visits	$30	
Inpatient Hospital	$600	$800
Coinsurance	**80%** of eligible expenses after satisfying deductible	**60%** of eligible expenses* after satisfying deductible
Out-of-Pocket Maximums (excludes Prescription Drug expenses, & amounts over Reasonable & Customary)	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Lifetime Maximum	Unlimited	Unlimited
Physician Office Visits	100% after co-payment	60% of eligible expenses* after satisfying deductible

January 1, 2022
This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program

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Preventive Care		
Adult Routine physical exams, Colorectal Cancer Screenings, Routine Digital Rectal Exams/Prostate Specific Antigen Test	**100%**	**60%** of eligible expenses* after satisfying deductible
Routine gynecological exams, including a PAP	**100%**	**60%** of eligible expenses* after satisfying deductible
Mammograms, as required	**100%**	**60%** of eligible expenses* after satisfying deductible
Pediatric Routine physical exams	**100%**	**60%** of eligible expenses* after satisfying deductible
Pediatric immunizations	**100%**	**60%** of eligible expenses* after satisfying deductible
Emergency Room Service – Co-pay waived if admitted	**80%** after **$250** co-pay	**80%**** after **$250 co-pay**
Ambulance Emergency Services only	**Ground Transportation:** 100% of eligible expenses. **Air Transportation:** 100% of eligible expenses. **Note:** Notification is required except in life threatening circumstances	

Benefit	In-Network	Out-of-Network
Maternity		
Office Visit	No Co-payment applies to Physician office visits for prenatal care after the first visit in which a **$30 PCP/$50 Specialist** co-payment applies	**60%** of eligible expenses* after satisfying deductible
Inpatient Admission	**$600** co-pay per confinement the 80% of eligible expenses	**$800** co-pay per confinement then **60%** of eligible expenses* after satisfying deductible
Allergy Testing and Treatment	**$30 PCP/ $50 Specialist** co-pay • Testing in Physician's office • Treatment (Injection administered by a Nurse) • Co-pay applies to Physicians office visit only (i.e. If Physician administers injection and bills as an office visit)	**60%** of eligible expenses* after satisfying deductible
Infertility Counseling, Testing and Treatment	**$50 Specialist co-pay** • Any combination of In-Network and Out-of-Network Benefits for infertility services is limited to a lifetime maximum of **$8,000** per Covered Person. If a Center of Excellence is used the lifetime maximum increases to **$20,000**	**60%** of eligible expenses* after satisfying deductible • Out-of-Network Benefits for infertility services is limited to a lifetime maximum of $4,000 per Cover Person

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Benefit	In-Network	Out-of-Network
Hospital Expenses Inpatient Stay in a Hospital Benefits are available for: • Services and supplies received during the Inpatient Stay • Room and board in a Semi-private Room (a room with two or more beds.)	**$600** inpatient co-pay per confinement then **80%** of eligible expenses	**$800** co-pay per confinement then **60%** of eligible expenses after satisfying deductible Notify Care Coordination: Please remember that you must notify Care Coordination as follows: • For elective admissions: 5 business days before admission • For non-elective admissions: as soon as is reasonably possible • For Emergency admissions within as soon as is reasonably possible
Surgical Expenses	**80%** of eligible expenses after satisfying deductible	**60%** of eligible expenses* after satisfying deductible
Spinal Manipulations/ Chiropractic Care	**$30 PCP/ $50 Specialist co-pay** Any combination of In-Network and Out-of-Network Benefits for Spinal Treatment is limited to 30 visits per calendar year. Visits exceeding plan limitation subject to medical claim review.	**60% of** eligible expenses* after satisfying deductible. Any combination of In-Network and Out-of-Network Benefits for Spinal Treatment is limited to 30 visits per calendar year. Visits exceeding plan limitation subject to medical claim review.

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Benefit	In-Network	Out-of-Network
Diagnostic Services (Lab, X-Ray, Ultrasound and other tests) Inpatient Outpatient	 **80%** of eligible expenses after satisfying deductible **80%** of eligible expenses after satisfying deductible	 **60%** of eligible expenses* after satisfying deductible **60%** of eligible expenses* after satisfying deductible
Physical Therapy Limited to 30 visits per calendar year for physical, occupational and speech therapy combined	**$50 Specialist co-pay**	**60%** of eligible expenses* after satisfying deductible
Speech & Occupational Therapy (Professional) Limited to 30 visits per calendar year for physical, occupational and speech therapy combined	**$50 Specialist co-pay**	**60%** of eligible expenses* after satisfying deductible
Durable Medical Equipment	**80%** of eligible expenses * after satisfying deductible	**60%** of eligible expenses* after satisfying deductible
Skilled Nursing Facility Care	**$600** inpatient co-pay per confinement then **80%** of eligible expenses **Any combination of In-Network and Out-of-Network Benefits is limited to 60 days per calendar year.**	**$800** co-pay per confinement then 60% of eligible expenses* after satisfying deductible. **Any combination of In-Network and Out-of-Network Benefits is limited to 60 days per calendar year.**

Benefit	In-Network	Out-of-Network
Home Health Care	**80%** of eligible expenses after satisfying deductible Care Coordination will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Any combination of In-Network and Out-of-Network Benefits is limited to 100 visits per calendar year. One visit equals four hours of skilled care services.	**60%** of eligible expenses* after satisfying deductible Care Coordination will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Any combination In-Network and Out-of-Network Benefits is limited to 100 visits per calendar year. One visit equals four hours of skilled care services.
Private Duty Nursing	**80%** of eligible expenses after satisfying deductible.	**60%** of eligible expenses* after satisfying deductible.
Hospice	**80%** of eligible expenses* after satisfying deductible	**60%** of eligible expenses* after satisfying deductible

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Benefit	In-Network	Out-of-Network
Hearing Care Hearing examinations and associated services **Hearing aids are covered up to a maximum of $5,000 per calendar year**	Routine Hearing Testing: **$30 PCP /** **$50 Specialist** co-pay • Covers hearing screenings as part of a routine preventive • Hearing aids are subject to deductible then 80% of eligible expenses	**60%** of eligible expenses* after satisfying deductible
Vision Care	Routine Vision Testing: 100% after **$30 PCP/$50 specialist** co-pay Covers one visit every 12	**60%** of eligible expenses* after satisfying deductible Covers one visit every 12 months
Mental Health Inpatient	**$600** inpatient co-pay per confinement then **80%** of eligible expenses	**$800** inpatient co-pay per confinement then **60%** of eligible expenses* after satisfying deductible. Notify Care Coordination: Please remember that you must notify Care Coordination as follows: • For elective admissions: 5 business days before admission • For non-elective admissions: as soon as is reasonably possible For Emergency admissions within as soon as is reasonably possible
No Limit on number of treatments or sessions		
Outpatient	**$30** co-pay	**60%** of eligible expenses* after satisfying deductible
No Limit on number of treatments or sessions		
Substance Abuse Inpatient Detoxification	**$600** inpatient co-pay per confinement then **80%** of eligible expenses	**$800** inpatient co-pay per confinement then **60%** of eligible expenses* after satisfying deductible
No Limit on number of treatments or sessions		

Rehabilitation Inpatient	**$600** inpatient co-pay per confinement then **80%** of eligible expenses	**$800** 60 inpatient co-pay **60 %** of eligible expenses* after satisfying deductible
No Limit on number of treatments or sessions		
Outpatient	**$30** co-pay	**60%** of eligible expenses* after satisfying deductible
No Limit on number of treatments or sessions		

Benefit	In-Network	Out-of-Network
Pharmacy Coverage Retail Purchases NETWORK Coverage is through Express Scripts 1-888-749-3878	Coverage up to 30-day supply • Tier 1 = $10 • Tier 2 = 40% ($45 Min/$100 Maximum) • Tier 3 = 50% ($65 Min/ $130 Maximum) Note: Tier 1 is referred to as Generic, Tier 2 is referred to as Name Brand Formulary and Tier 3 is referred to as name Brand Non-Formulary	n/a
Mail Order Purchases **NETWORK** Coverage is through Express Scripts 866-841-5482 **Out-of-Pocket Maximum** (combined retail and mail order): Individual: $2,000 Family: $4,000	Coverage up to 90-day supply • Tier 1 = $20 • Tier 2 = 40% ($85 Min/$225 maximum) • Tier 3 = 50% ($155 Min/ $305 maximum) Note: Tier 1 is referred to as Generic, Tier 2 is referred to as Name Brand Formulary and Tier 3 is referred to as Name Brand Non-Formulary.	n/a

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* Out of Network Eligible Expenses are equal to Reasonable and Customary Expenses
**Emergency Room - The plan will only pay 60% for out-of-network providers if not a true emergency
+ **Office visit, emergency room and hospital copays will count towards the out-of-pocket maximum.**

UHC Customer Service	866-679-0946
Group Number	702551
United Healthcare Provider Search	www.myuhc.com

***Includes mental health and substance abuse**