

City of Stevens Point

Option 3 PPO Summary of Benefits



A UnitedHealthcare Company

Medical Benefits

Covered Services	In-Network Providers	Non-Network Providers
Calendar Year Deductible		
Per Person	\$2,500	\$5,000
Family	\$5,000	\$10,000
Maximum Out-of-Pocket Expense		
Per Calendar Year		
Per Person	\$3,500	\$7,000
Family	\$7,000	\$14,000
Primary Care Physician Office Visits	80% after deductible	60% after deductible
Specialist Office Visits	80% after deductible	60% after deductible
Physician Office Services	80% after deductible	60% after deductible
Urgent Care Visit	80% after deductible	60% after deductible
Emergency Room	\$100 co-pay (waived if admitted within 24-hours) 100% after In-Network Deductible	
Ambulance	80%; after in-network deductible	
Durable Medical Equipment	80% after deductible	60% after deductible
Outpatient Diagnostic X-ray and Lab	80% after deductible	60% after deductible
Outpatient Hospital Services	80% after deductible	60% after deductible
Inpatient Hospital Services	80% after deductible	60% after deductible
Physical Therapy	80% after deductible	60% after deductible
Speech, Hearing Occupational Therapy	80% after deductible	60% after deductible
Preventive/Routine Exams	100%; deductible waived	60% after deductible
Immunizations	100%; deductible waived	60% after deductible
Preventive/Routine Diagnostic Lab and X-Rays	100%; deductible waived	60% after deductible
Mammograms	100%; deductible waived	60% after deductible
Preventive/Routine Pap Test	100%; deductible waived	60% after deductible
Preventive/Routine PSA and Prostate	100%; deductible waived	60% after deductible
Preventive/Routine Colonoscopy, Sigmoidoscopy and Other Similar Procedures	100%; deductible waived	60% after deductible
Preventive/Routine Hearing Exams	100%; deductible waived	60% after deductible
Women's Preventive Health Care	100%; deductible waived	60% after deductible

UMR Customer Service: 1-800-826-9781 www.umar.com
Submit Claims to: UMR P.O. Box 30541 Salt Lake City, UT 84130-0541

This is a summary of benefits and not a guarantee. Benefit payments are subject to all plan provisions and eligibility requirements at the time services are rendered. The plan document and summary plan description are the official sources of information. In the event of a discrepancy, the plan document and summary plan description will prevail.

Prescription Drug Benefits

Maximum Out-of-Pocket Expense

Per Calendar Year

Per Person	\$3,500
Family	\$7,000

Retail Pharmacy Option – Participating Pharmacy

Co-Pay Per Prescription (34-day supply)

For Generic Drugs	\$10
For Preferred Brand Drugs	\$20
For Non-Preferred Brand Drug	\$40

Retail 90 Rx Pharmacy Option – Participating Pharmacy

Co-Pay Per Prescription (90-day supply)

For Generic Drugs	\$20
For Preferred Brand Drugs	\$40
For Non-Preferred Brand Drugs	\$80

Mail Order Option – OptumRx

Co-Pay Per Prescription (90-day supply)

For Generic Drugs	\$20
For Preferred Brand Drugs	\$40
For Non-Preferred Drugs	\$80

Specialty Option – OptumRx

Co-Pay Per Prescription (30-day supply)

For Generic Drugs	\$40
For Preferred Brand Drugs	\$40
For Non-Preferred Drugs	\$40

OptumRx Member Services: 1-877-559-2955



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