

*Premium – Premium – Premium – Premium – Premium – Premium*



## Premium PPO Plan

# *Benefit Summary*

Kyrene Employees Benefit Trust  
Policy 210475

*Using the*  
UnitedHealthcare  
Choice Plus Network  
*(Please designate this network when using the  
myuhc.com or general UnitedHealthcare  
provider search tools)*

*Premium – Premium – Premium – Premium – Premium - Premium*

**Benefit Summary**

TYPES OF COVERAGE	NETWORK COPAYMENT	NON-NETWORK COPAYMENT
<p>This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the Summary Plan Description that you will receive upon enrolling in the Plan.</p> <p>If this Benefit Summary conflicts in any way with the Summary Plan Description, the Summary Plan Description shall prevail.</p> <p>Only those services that are determined by the Plan to be medically appropriate are covered.</p> <p>In-network health care services under this benefit plan are covered only when provided, arranged or authorized by a participating Physician.</p> <p>Where benefits are subject to day, visit and or dollar limits, such limits will apply to use of benefits for both in-network and out-of-network separately, except where mandated by state law.</p>	<p><b>United HealthCare Insurance Company</b> Services received from network providers and otherwise covered by United HealthCare Insurance Company.</p> <p><b>Annual Deductible:</b> \$0 per covered person per year.</p> <p><b>Out-of-Pocket Maximum:</b> \$2,000 per covered person, not to exceed \$5,000 per family per year.</p> <p>Copays for inpatient hospital, emergency room, urgent care, skilled nursing, and hospice services mental health/substance abuse, prescriptions drugs do not apply to this maximum.</p> <p>Charges over the Reasonable and Customary limit are the covered person's responsibility and do not apply toward deductible and out-of-pocket maximums.</p> <p style="text-align: center;"><b>Maximum Lifetime Benefit:</b> \$2,000,000 per covered person, combined in and out of network benefits.</p> <p style="text-align: center;"><b>The maximum lifetime benefit covers the entire duration of your coverage or your dependent(s) coverage through the Kyrene Employee Benefit Plan. This benefit will not reset if you or your dependent(s) change from one Kyrene Employee Benefit Plan to another. This benefit is combined to cover both in and out of network usage for all plans.</b></p>	<p><b>United HealthCare Insurance Company.</b> Services received from non-network providers and covered by United HealthCare Insurance Company.</p> <p><b>Annual Deductible:</b> \$500 per covered person per year not to exceed \$1,000 for all covered persons in a family per year.</p> <p><b>Out-of-Pocket Maximum:</b> \$6,000 per covered person, not to exceed \$18,000 per family per year.</p> <p>Copays for inpatient hospital, emergency room, urgent care, skilled nursing and hospice services, mental health/substance abuse, prescriptions drugs, do not apply to this maximum.</p> <p>Charges over the Reasonable and Customary limit are the covered person's responsibility and do not apply toward deductible and out-of-pocket maximums.</p>
	<b>YOU ARE RESPONSIBLE FOR</b>	<b>YOU ARE RESPONSIBLE FOR</b>
1. Allergy Services in a Physician's Office	10% of eligible expenses.	40% of eligible expenses after deductible
2. Dental Services – Accident Related	10% of eligible expenses for services in a physician's office. 10% of eligible expenses for professional fees for surgical and medical services. \$250 copay per confinement then 10% of eligible expenses for inpatient hospital and related health services.	40% of eligible expenses after deductible for services in a physician's office. 40% of eligible expenses after deductible for professional fees for surgical and medical services. \$250 copay per confinement then 40% of eligible expenses after deductible for inpatient hospital and related health services. <b>Surgical services and confinement must be prior authorized.</b>
3. Diabetic Supplies and Equipment	10% of eligible expenses.	40% of eligible expenses after deductible.
4. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are subject to the combined limit of \$10,000 per covered person per year.	10% of eligible expenses.	40% of eligible expenses after deductible.
5. Emergency Outpatient Services and Supplies	\$150 copay per visit, then 10% of eligible expenses. If admitted within 24 hours for the same condition, copay is waived.	\$150 copay per visit, then 40% of eligible expenses after deductible. If admitted within 24 hours for the same condition, copay is waived.
Ambulance	100% coverage for Emergency.	100% coverage after deductible for Emergency.

**Only medically necessary services are covered**

TYPES OF COVERAGE	NETWORK COPAYMENT	NON-NETWORK COPAYMENT
<p><b>6. Eye Examinations</b>-services for medical conditions of the eye. For information regarding routine vision exams contact VSP at 1-800-821-8130.</p>	10% of eligible expenses.	40% of eligible expenses after deductible.
<p><b>7. Family Planning</b> – Refer to the plan document for more details on covered expenses.</p> <p><b>Office Visit</b></p> <p><b>Sterilization</b></p>	<p>10% of eligible expenses.</p> <p>10% of eligible expenses.</p>	<p>40% of eligible expenses after deductible.</p> <p>40% of eligible expenses after deductible.</p>
<p><b>8. Home Health Agency Services</b> (including Infusion Therapy services) Payable to 120 visits (to a max of 4 hours per visit) not to exceed \$10,000 per covered person per year.</p>	10% of eligible expenses.	40% of eligible expenses after deductible. <b>Services must be prior authorized.</b>
<p><b>9. Hospice Care</b> Maximum of \$20,000 per person per lifetime, including bereavement services.</p>	10% of eligible expenses.	40% of eligible expenses after deductible. <b>Services must be prior authorized.</b>
<p><b>10. Inpatient Hospital and Related Health Services</b></p>	\$250 copay per confinement then 10% of eligible expenses.	\$250 copay per confinement then 40% after deductible. <b>Confinement must be prior authorized.</b>
<p><b>11. Maternity Services</b></p>	<p>10% of eligible expenses for medical services in a physician’s office.</p> <p>10% of eligible expenses for professional fees for surgical and medical services.</p> <p>\$250 copay per confinement then 10% of eligible expenses for inpatient hospital and related health services.</p> <p>10% of eligible expenses for outpatient surgery, lab &amp; radiology services.</p>	<p>40% of eligible expenses after deductible for medical services in a physician’s office.</p> <p>40% of eligible expenses after deductible for professional fees for surgical and medical services.</p> <p>\$250 copay per confinement then 40% of eligible expenses after deductible for inpatient hospital and related health services.</p> <p>40% of eligible expenses after deductible for outpatient surgery, lab &amp; radiology services</p> <p><b>Surgical services and confinement must be prior authorized.</b></p>
<p><b>12. Medications (Drugs)</b></p> <p><b>Retail Drugs:</b> Under the prescription Drug Network, participating retail pharmacies have entered into an agreement to offer drugs at a discounted cost plus a dispensing fee. Present your medical ID card to the network pharmacy. One copay applies toward a <b>31-day supply</b>.</p> <p><b>Mail Order:</b> By using the Mail Order Program, in addition to a significant discount off the price of the drug, you may receive up to <b>90-day supply</b> of non-emergency, extended use, maintenance medication.</p> <p>Please see the plan document for all guidelines and exclusions applicable to the Medications benefit.</p>	<p>No deductible</p> <p><b>Retail Drugs:</b> <b>Tier One Drugs:</b> 100% after \$15 copay per order or refill. <b>Tier Two Drugs:</b> 100% after \$30 copay per order or refill. <b>Tier Three Drugs:</b> 100% after \$60 copay per order or refill.</p> <p><b>Mail Order Drugs:</b> <b>Tier One Drugs:</b> 100% after \$30 copay per order or refill. <b>Tier Two Drugs:</b> 100% after \$60 copay per order or refill. <b>Tier Three Drugs:</b> 100% after \$120 copay per order or refill</p>	<p>No coverage for drugs purchased from non-participating providers.</p> <p>No coverage</p>
<p><b>13. Medical Services in a Physician’s Office including</b></p>	10% of eligible expenses.	40% of eligible expenses after deductible.
<p><b>14. Mental Health and Substance Abuse Services – Outpatient</b></p> <p>New for 2009:</p> <p>UnitedHealthcare Care24 EAP – 3 Face-to-Face Visits Per Issue Per Year</p>	<p>See Plan Document for coverage.</p> <p>Prior Authorization is required from the Behavioral Health Program – Please call MH/SA Number on ID Card</p>	<p>See Plan Document for coverage.</p> <p>Prior Authorization is required from the Behavioral Health Program – Please call MH/SA Number on ID Card</p>
<p><b>15. Mental Health and Substance Abuse Services - Inpatient</b></p>	<p>See Plan Document for coverage.</p> <p>Prior Authorization is required from the Behavioral Health Program – Please call MH/SA Number on ID Card</p>	<p>See Plan Document for coverage.</p> <p>Prior Authorization is required from the Behavioral Health Program – Please call MH/SA Number on ID Card</p>

<b>TYPES OF COVERAGE</b>	<b>NETWORK COPAYMENT</b>	<b>NON-NETWORK COPAYMENT</b>
<b>16. Professional Fees for Surgical and Medical Services</b>	10% of eligible expenses.	40% of eligible expenses after deductible. <b>Surgical services must be prior authorized.</b>
<b>17. Prosthetic Devices</b> \$10,000 per limb per covered person for appliance and supplies, repair, servicing and replacement. See plan document for detailed coverage.	10% of eligible expenses.	40% of eligible expenses after deductible. <b>Services must be prior authorized.</b>
<b>18. Orthotics (except for feet)</b> \$3,000 maximum per covered person per year. Antiembolism and vascular support garments limited to 2 per year.  <b>Foot Orthotics</b> \$1,000 maximum per covered person per year for corrective shoes and other supportive appliances for the feet. Limited to once in a 12 month period for adults and once in a six month period for children under age 19 when replacement is required by growth	10% of eligible expenses.  10% of eligible expenses.	40% of eligible expenses after deductible. Services must be prior authorized.  40% of eligible expenses after deductible. <b>Services must be prior authorized.</b>
<b>19. Outpatient Surgery, Lab &amp; Radiology Services</b>	10% of eligible expenses.	40% of eligible expenses after deductible. <b>Services must be prior authorized.</b>
<b>20. Reconstructive Surgery</b>	10% of eligible expenses for services in a physician's office.  10% of eligible expenses for professional fees for surgical and medical services.  \$250 copay per confinement then 10% of eligible expenses for inpatient hospital and related health services.	40% of eligible expenses after deductible for services in a physician's office.  40% of eligible expenses after deductible for professional fees for surgical and medical services.  \$250 copay per confinement then 40% of eligible expenses after deductible for inpatient hospital and related health services.  <b>Surgical services and confinement must be prior authorized.</b>
<b>21. Rehabilitation Services - Outpatient (Physical, Occupational, Speech and Cardiac/Pulmonary therapy)</b>  Outpatient rehab is limited to 50 visits per covered person per year combined for all outpatient therapies in and out of network.	10% of eligible expenses.	40% of eligible expenses after deductible.  <b>Services must be prior authorized.</b>
<b>22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b> Limited to 120 days per year.	10% of eligible expenses.	40% of eligible expenses after deductible. <b>Services must be prior authorized.</b>
<b>23. Spinal Manipulation</b> —Services for back-related care only, for adults 18 years or older. Limited to \$500 per individual and \$1500 per family per year.	10% of eligible expenses.	40% of eligible expenses after deductible.
<b>24. Transplantation Health Services</b>	10% of eligible expenses.	40% after deductible. <b>Services must be prior authorized.</b>
<b>25. Urgent Care Center</b>	\$25 copay per visit, then 10% of eligible expenses.	\$25 copay per visit, then 40% of eligible expenses after deductible.
<b>26. Wellness/Preventive Care includes:</b> Please refer to the Kyrene Employee Benefit Trust Plan Document for guidelines and coverage details.  REVISED BENEFIT FOR 2009: Mammograms are payable as follows: Ages 35-40: One Screening Baseline Mammogram Age 41 and Up: One Annual Mammogram	10% of eligible expenses. Not subject to deductible.	Preventive care is not covered for Out of Network (Non-Network) Providers.

**Refer to the Kyrene Employee Benefit Trust Plan Document for a detailed General Exclusions Section that lists items not covered by the plan. This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage.**