

U.S. BENEFITS

How do you Benefit?



HEALTH PLAN SUMMARY

Effective Dates 1/1/2019 - 12/31/2019	UMR	
	In Network	Out of Network
MEDICAL		
Lifetime Plan Maximum	Unlimited	Unlimited
Calendar Year Deductible:		
<i>Individual</i>	\$250	\$1,000
<i>Family</i>	\$500	\$2,000
Out of Pocket Maximum:		
<i>Individual</i>	\$2,000	\$6,000
<i>Family</i>	\$4,000	\$12,000
Coinsurance	100%	70%
Physician Office Visits:		
<i>Primary Care</i>	\$15	Deductible and coinsurance
<i>Specialists</i>	\$25	
<i>Any services in addition to the office visit will be subject to the deductible (e.g. lab work, x-rays)</i>		
Hospital Visit Copayments:		
<i>Inpatient</i>	\$250 per admission, then deductible	\$250 per admission, then deductible and coinsurance
<i>Outpatient</i>	\$100 per procedure, then deductible	\$100 per procedure, then deductible and coinsurance
<i>Emergency Room</i>	\$125 per visit, then 100%	\$125 per visit, then deductible and coinsurance
<i>Copay waived if admitted within 24 hours</i>		
<i>Urgent Care Center</i>	\$50 per visit	\$50 per visit
Preventive Exams	100% Coverage	Not Covered
Immunizations	100% Coverage	100% for flu and shingles only
Chiropractic Services	\$25 per visit	\$25 per visit, then deductible and coinsurance
Skilled Nursing	Deductible	Deductible and coinsurance
<i>Limited to 60 days per calendar year</i>		
Lab and X-Ray	Deductible	Deductible and coinsurance
Home Health Care	Deductible	Deductible and coinsurance
<i>\$25,000 maximum annual benefit, combined with private duty nursing</i>		
Hospice Care	80% after deductible	80% after deductible
Durable Medical Equipment	80% after deductible	80% after deductible

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Mental Health & Alcohol/Drug Abuse:		
<i>Inpatient</i>	\$250 per admission, then deductible	\$250 per admission, then deductible and coinsurance
<i>Outpatient</i>	\$25 per visit, then deductible	50% after deductible
Infertility Treatment	50% after deductible (\$10,000 Lifetime Maximum)	Not Covered
PRESCRIPTION DRUG		
	Retail (After \$50 deductible):	Mail Order:
Generic	\$5	\$10
Preferred Brand Name	\$20	\$40
Non-Preferred Brand Name	\$35	\$7-
DENTAL		
Calendar Year Deductible:		
<i>Individual</i>		\$50
<i>Family</i>		\$150
Annual Maximum		\$1,500 per person
Coinsurance:		
<i>Preventive/Diagnostic</i>		100% (Deductible waived)
<i>Basic Services</i>		80% after deductible
<i>Major Services</i>		50% after deductible
<i>Orthodontia</i>		50% (Deductible waived)
Endodontics		80% after deductible
Periodontics		80% after deductible
Oral Surgery:		
<i>Simple Extractions</i>		80% after deductible
<i>Surgical Extractions of Teeth (except Wisdom Teeth)</i>		80% after deductible
<i>Surgical Extractions of Wisdom Teeth</i>		Covered under Major Medical
PAYROLL DEDUCTIONS		
Employee Only	\$25/month	\$12.50/semi-monthly
Employee + Spouse	\$90/month	\$45/semi-monthly
Employee + Child(ren)	\$70/month	\$35/semi-monthly
Family	\$145/month	\$72.50/semi-monthly