

Benefits at a Glance

Have benefit or healthcare questions?

Care Coordinators are ready to help you

*Sometimes we call you —
call us back so we can help you!*

Call us **BEFORE** you see a
specialist or get a service listed
on the back of your ID card!

- Save money on specialist copays by getting a referral from your primary care provider (PCP). When your PCP calls us **BEFORE** your specialist visit, your copay gets lowered by half.
- Have your doctor call us **BEFORE** you get a service listed on the back of your ID card. If you don't, in certain cases, your claim may not be paid at all.

Call Monday – Friday 8:30 AM – 10 PM EST
(866) 686-0003 • www.uhh.org



Medical — Blue Cross Blue Shield PPO	You pay	
	Network	Non-Network
Calendar Year Deductible	\$200 per person \$600 per family	\$400 per person \$800 per family
Basic Inpatient and Outpatient Benefits	Network	Non-Network
Inpatient Hospitalization	\$0 after deductible	40% after deductible
Hospital Outpatient and Diagnostic Services	\$0 after deductible	40% after deductible
Ambulatory Surgical Services	\$0 after deductible	40% after deductible
Skilled Nursing Facility — <i>Up to 70 total days per person each year</i>	\$0 after deductible	40% after deductible
Home Healthcare Services — <i>Up to 200 total visits per person each year</i>	\$0 after deductible	40% after deductible
Hospice Care — <i>Up to 210 total lifetime visits per person</i>	\$0 after deductible	40% after deductible
Hospital Emergency Room — <i>True emergency</i>	\$0 after deductible	\$0 after deductible
Hospital Emergency Room — <i>Non-emergency/routine care</i>	20% after deductible	60% after deductible

Medical and Surgical Benefits	Network	Non-Network
Lifetime Maximum Benefit per Person	\$1,000,000	
Preventive Care		
Well Baby Care — <i>For children up to 18 months of age</i>	\$0	Not Covered
Immunizations	\$20 copay	Not Covered
Routine Colonoscopy or Routine PSA Tests — <i>Frequency limits and age restrictions apply</i>	\$0	Not Covered
Preventive Exam — <i>1 per person each year</i>	\$0	Not Covered
Office Visits		
Primary Care Provider (PCP)	\$10 copay	40% after deductible
Specialist — <i>When your PCP calls the Care Coordinators first</i>	\$10 copay	40% after deductible
Specialist — <i>When your PCP DOESN'T call the Care Coordinators first</i>	\$20 copay	40% after deductible
Mental Health/Substance Abuse Office Visit	\$20 copay	40% after deductible
Chiropractic	\$20 copay	40% after deductible
Routine Podiatric	\$20 copay	40% after deductible
Urgent Care		
Urgent Care Center	\$20 copay	40% after deductible
Ambulance	First \$50 in charges — \$0 After first \$50 in charges — 40% after deductible	
Other Services and Supplies		
Certified Diabetes Educator — <i>Up to \$200 per person each year</i>	\$0	Not Covered
Registered Dietitian — <i>Up to \$200 per person each year</i>	\$0	Not Covered
Speech and Physical Therapy — <i>Speech therapy for children limited to \$2,500 per person each year</i>	\$0 after deductible	40% after deductible
Durable Medical Equipment	\$0 after deductible	40% after deductible
Prescription Drugs — Hospitality Rx <i>Available at most pharmacies; not available at CVS/Longs or Wal-Mart</i>	Retail <i>Up to a 34-day supply</i>	Mail Order <i>Up to a 60-day supply</i>
Annual Maximum Benefit — <i>Families with at least one person age 65 or older during the year</i>	\$12,500 per family	
Annual Maximum Benefit — <i>Families with no one age 65 or older during the year</i>	\$7,500 per family	
Generic Drugs	\$15 copay	\$15 copay
Brand Name Drugs	\$30 copay	\$30 copay
Specialty Drugs	25% (\$35 maximum copay)	

Vision — Davis Vision	
Covered person	Maximum benefit
Retirees and spouses	The Plan pays \$75 every 24 months
Dependent children age 19 and older	The Plan pays \$75 every 24 months
Dependent children under age 19	The Plan pays \$75 every 12 months

Life Insurance	
<i>Only available to certain grandfathered retirees</i>	
Life Insurance	The Plan pays \$5,000

Dental — Delta Dental PPO	
<i>Only available to certain grandfathered retirees and their dependents</i>	
Covered services	You Pay
Calendar Year Deductible	\$25 per person \$100 per family
Dental Services (Non-Orthodontic) Calendar Year Maximum Benefit	\$2,000 per person
Diagnostic and Preventive Services	\$0
Emergency Palliative Services	\$0
Minor & Major Restorative Services	20% after deductible
Prosthetic Services	20% after deductible
Orthodontic Services <i>Children under age 19 only</i>	40%
Orthodontic Lifetime Maximum Benefit	\$500 per child