UnitedHealthcare — Core Value Plan

PERS HEALTH INSURANCE PROGRAM
Public Employees Retirement System

Benefit Description	Non-Medicare Choice Plus Core Value	
	In-Network	**Out-of-Network**
Eligible Providers	Preferred physicians and facilities	Any Licensed Physician or facility
	Member Pays:	
Calendar Year Deductible	$1,000 per Individual/$2,000 per Family	
Calendar Year Medical/Pharmacy Out-of-Pocket Maximum	$6,350 + $1,000 Deductible = $7,350/Individual; $12,700 + $2,000 Deductible = $14,700/Family	
Preventive Care	Covered in full per ACA guidelines	40% after deductible per ACA guidelines
Inpatient Care:		
• Inpatient Hospital Care	• 20% after deductible	• 40% after deductible
• Skilled Nursing Facility	• 20% after deductible	• 40% after deductible
Outpatient Care:		
• Physician Office Visits	• $20 copay, no deductible	• 40% after deductible
• Specialist Office Visits	• $20 copay, no deductible	• 40% after deductible
• Outpatient Surgery	• 20% after deductible	• 40% after deductible
• Ambulance (air-ground)	• 20% after deductible	• 20% after deductible
• Emergency Services	• $200 copay, then 20%, no deductible	• $200 copay, then 20%, no deductible
• Urgent Care	• $20 copay, no deductible	• 40% after deductible
• DME	• 20% after deductible	• 40% after deductible
• Lab Test	• 20%, no deductible	• 40% after deductible
• X-ray	• 20%, no deductible	• 40% after deductible
• Diagnostic Procedures (CT/MRI, PET)	• 20%, no deductible	• 40% after deductible
• Physical Therapy[1]	• $20 copay, no deductible	• 40% after deductible
• OT/ST Therapies[1]	• $20 copay, no deductible	• 40% after deductible

Benefit Description	Non-Medicare Choice Plus Core Value	
	In-Network	**Out-of-Network**
Other Services:		
• Alternative Care[2]	• $30 copay, no deductible	• 40% after deductible
Calendar Year Pharmacy Out-of-Pocket Maximum	Combined with Medical	
Prescription Drugs:		
• Brand	• 40%, no deductible	
• Generic	• 40%, no deductible	
• Specialty	• 40%, no deductible	
Rates (per member, per month):		
• Adult	• $1,373.08	
• Child	• $416.05	

This is a summary of benefits only, for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this guide and the health plan document, the information in the health plan document shall prevail.

1 Outpatient rehab: OT = Occupational Therapy, PT = Physical Therapy, ST = Speech Therapy. Limited to 20 visits per therapy, per calendar year.

2 Spinal Manipulation is limited to 20 visits and acupuncture is limited to 12 visits per calendar year. Massage therapy not covered.