



Redlands Unified School District

Summary of 2017-2018 United HealthCare PPO Plans

Effective Date	07/01/2017		07/01/2017	
Renewal Date	07/01/2018		07/01/2018	
Carrier Name	United HealthCare Insurance Company		United HealthCare Insurance Company	
Plan Name	PPO 500 - \$10/30/10 Rx + Cost		PPO 750 - \$15/50/15 Rx + Cost	
Eligible Class	Eligible Employees		Eligible Employees	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
General Plan Information				
Annual Deductible/Individual	\$500	\$1,000	\$750	\$1,500
Annual Deductible/Family	\$1,500	\$3,000	\$2,250	\$4,500
Coinsurance	90%	70%	80%	60%
Office Visit/Exam	\$30/Visit; deductible waived	70%	\$40/Visit; deductible waived	60%
Outpatient Specialist Visit	\$30/Visit; deductible waived	70%	\$40/Visit; deductible waived	60%
Annual Out-of-Pocket Limit/Individual	\$3,000 Rx not included	\$6,000 Rx not included	\$3,000 Rx not included	\$6,000 Rx not included
Annual Out-of-Pocket Limit/Family	\$9,000 Rx not included	\$18,000 Rx not included	\$9,000 Rx not included	\$18,000 Rx not included
Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Inpatient Hospital Services				
Inpatient Hospitalization	90%	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)	80%	60% plus \$500 admission fee after the deductible has been satisfied (waived for emergency)
Semi-Private Room & Board; Including Services and Supplies	90%	70%	80%	60%
Emergency Services				
Emergency Room	90%	90%	80%	80%
Mental Health Benefits				
Inpatient Care	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required
Outpatient Care	90% prior MHN authorization required	70% prior MHN authorization required	90% prior MHN authorization required	70% prior MHN authorization required (waived for emergency)
Alcohol & Abuse				
Inpatient Care				
Inpatient Hospitalization	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required
Inpatient Detoxification Services	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required	90% prior MHN authorization required	70% plus \$500 admission fee after the deductible has been satisfied (waived for emergency) prior MHN authorization required
Outpatient Care				
Outpatient Services	90% prior MHN authorization required	70% prior MHN authorization required	90% prior MHN authorization required	70% prior MHN authorization required
Outpatient Detoxification Services				

CONFIDENTIAL: The information in this chart is intended for the exclusive use of the recipient in connection with the recipient's review of this proposal. It is not intended for any other purpose. The information described on this page is only intended to be a summary of your benefits. It does not include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description (SPD) for a complete summary of your benefits. If the information on this page conflicts in any way with the SPD, the contract provisions of the appropriate policy or plan document (available through your employer) will prevail.



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Eligible Class	Eligible Employees		Eligible Employees	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Prescription Drug Benefits				
Prescription Drug Deductible				
Generic	\$10 copay/Tier 1 Pharmacy \$10 copay +\$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)
Brand (Formulary/Preferred)	\$30 copay/Tier 1 Pharmacy \$30 copay +\$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)	\$50 copay/Tier 1 Pharmacy; \$50 copay + \$15/Tier 2 Pharmacy provided by ESI (see www.express-scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy; provided by ESI (see www.express-scripts.com for a list of pharmacies)
Brand (Non-Formulary/Non-preferred)	\$10 copay/Tier 1 Pharmacy \$10 copay +\$15/Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (see www.express-scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (see www.express-scripts.com for a list of pharmacies)	\$15 copay/Tier 1 Pharmacy; \$15 copay + \$15/Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (see www.express-scripts.com for a list of pharmacies)	50% + an additional \$15 fee applies per prescription for a Tier 2 Pharmacy + cost difference between generic and brand when generic equivalent is available; (see www.express-scripts.com for a list of pharmacies)
Number of Days Supply	30 days	30 days	30 days	30 days
Mail Order				
Generic	\$20 copay provided by Express Scripts	Not covered	\$30 copay provided by Express Scripts	Not covered
Brand (Formulary/Preferred)	\$60 copay provided by Express Scripts	Not covered	\$100 copay provided by Express Scripts	Not covered
Brand (Non-Formulary/Non-preferred)	\$20 copay plus cost difference between generic and brand when generic equivalent is available; provided by Express Scripts	Not covered	\$30 copay plus cost difference between generic and brand when generic equivalent is available; provided by Express Scripts	Not covered
Number of Days Supply for Mail Order	90 days	Not covered	90 days	N/A
Other Services and Supplies				
Chiropractic Services	90% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined	70% chiro/phys/occ therapy combined; in/out of network combined	80% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined	60% limited to 24 visits/calendar year; chiro/phys/occ therapy combined; in/out of network combined

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