

Rock Island County – Base Plan Summary of Benefits



A UnitedHealthcare Company

Medical Benefits

Covered Services	Tier 1 In-Network Unity Point	Tier 2 All Other In-Network Providers	Tier 3 - Out of Network
Calendar Year Deductible		(Applies Only to Inpatient Hospital)	
Per Person	\$0	\$400	\$800
Family	\$0	\$1,200	\$2,400
Calendar Year Max Out-of-Pocket Expense			
Per Person	\$3,000	\$3,000	\$4,000
Family	\$9,000	\$9,000	\$12,000
Primary Care Physician Office Visits	\$20 copay	Covered as tier 1	40% after deductible
Specialist Office Visits	\$30 copay	Covered as tier 1	40% after deductible
Teledoc – Telemedicine “Virtual” Visit	\$0 copay	\$0 copay	Not Applicable
Urgent Care Visit	\$30 copay	Covered as tier 1	40% after deductible
Emergency Room		15%; deductible does not apply	
Ambulance		15%; deductible does not apply	
Durable Medical Equipment	15%	Covered as tier 1	40% after deductible
Outpatient Diagnostic X-ray and Lab	15%	Covered as tier 1	40% after deductible
Outpatient Hospital Services	15%	Covered as tier 1	40% after deductible
Inpatient Hospital Services	\$250 copay per admit then 15%	\$250 copay per admit then 20% after \$400 individual or \$1,200 family deductible	\$250 copay per admit then 40% after tier 3 deductible
Outpatient Physical Therapy	15%	Covered as tier 1	40% after deductible
Speech, Hearing Occupational Therapy	15%	Covered as tier 1	40% after deductible
Preventive/Routine Exams	0%	Covered as tier 1	40% after deductible

UMR Customer Service: 1-800-826-9781 www.umar.com

Submit Claims to: UMR P.O. Box 30541 Salt Lake City, UT 84130-0541

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Prescription Drug Benefits

Retail Pharmacy Option – Participating Pharmacy

Co-Pay Per Prescription (30-day supply)

For Generic Drugs	\$15
For Preferred Brand Drugs	\$30
For Non-Preferred Brand Drug	\$60

Rock Island County – Optional Plan 1 Summary of Benefits



A UnitedHealthcare Company

Medical Benefits

Covered Services	Tier 1 In-Network Unity Point	Tier 2 All Other In-Network Providers	Tier 3 – Out of Network
Calendar Year Deductible			
Per Person	\$500	\$1,000	\$2,000
Family	\$1,500	\$3,000	\$6,000
Calendar Year Max Out-of-Pocket Expense			
Per Person	\$3,000	\$3,000	\$4,000
Family	\$9,000	\$9,000	\$12,000
Primary Care Physician Office Visits	\$25 copay	Covered at tier 1	40% after deductible
Specialist Office Visits	\$40 copay	Covered at tier 1	40% after deductible
Teledoc – Telemedicine “Virtual Visit”	\$0 copay	\$0 copay	Not applicable
Urgent Care Visit	\$40 copay	Covered at tier 1	40% after deductible
Emergency Room		20% after tier 1 deductible	
Ambulance		20% after tier 1 deductible	
Durable Medical Equipment	20% after \$500 individual deductible or \$1,500 family deductible	Covered as tier 1	40% after out-of-network deductible
Outpatient Diagnostic X-ray and Lab	20% after deductible	Covered as tier 1	40% after deductible
Outpatient Hospital Services	20% after deductible	Covered as tier 1	40% after deductible
Inpatient Hospital Services	20% after tier 1 deductible	25% after tier 2 deductible	40% after deductible
Outpatient Physical Therapy	20% after deductible	Covered as tier 1	40% after deductible
Speech, Hearing Occupational Therapy	20% after deductible	Covered as tier 1	40% after deductible
Preventive/Routine Exams	0%	Covered as tier 1	40% after deductible

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Prescription Drug Benefits

Retail Pharmacy Option – Participating Pharmacy

Co-Pay Per Prescription (30-day supply)

For Generic Drugs	\$15
For Preferred Brand Drugs	\$40
For Non-Preferred Brand Drug	\$80