



OUT-OF-AREA DEPENDENTS

Your employer is a member of VEBA. You can choose to cover any eligible dependents in your VEBA benefit plan selection. This includes your dependents who live with you as well as those who live away from home, in another part of California, or in another state. The rest of this flyer describes benefits for your dependents who live out-of-area.

About Out-of-Area Dependent Plan Coverage

While we try to match your out-of-area dependent's health plan as close as possible to the health plan you enroll in, sometimes, we need to place your out-of-area dependents in another plan. That's because we want to make sure they have access to a provider network wherever they live. Here's what you need to know:

1. The monthly premium cost for out-of-area dependents is the same as it is for dependents who live at home.
2. The plan we enroll your dependents in is based on their out-of-area address.
3. Even if you enroll in an HMO plan, based on your dependent's address, he or she may be enrolled in a different plan— either HMO or PPO plan— with different copays and benefits amounts. Again, it depends on their address.
4. You must include your dependent's out-of-area address on the enrollment application. This is so they can be placed in an out-of-area plan that has a local provider network.
5. Dependents will remain in their out-of-area plan unless they change their permanent address. This means they cannot switch back to your HMO or PPO plan if they return home for a short period such as winter, spring, or summer break.
6. Dependents who are enrolled in an HMO plan must choose a PCP within 30 miles of their out-of-area address.

Remember, if you are in an HMO plan, we will try to keep your dependent in an HMO plan. However, based on your dependent's address, we may have to enroll him or her in the out-of-area PPO plan.

The chart below describes what plans are available to your Out-of-Area Dependents, based on the plan you enroll in and their out-of-area address. The summary of benefits is shown on the back page of this flyer.

Your Health Plan	Dependents living IN California, but OUT-SIDE the San Diego Area	Dependents living OUTSIDE of California
UnitedHealthcare HMO Plan	Based on dependent's out-of-area address, dependent will be enrolled in either a UnitedHealthcare HMO or UMR PPO plan.	Based on dependent's out-of-state address, dependent will be enrolled in a PPO plan
UMR PPO Plan	Your dependent will be enrolled in a California UMR PPO plan.	Based on dependent's address, his or her out-of-area PPO plan may not be the same as yours, meaning network, copayment amounts, and deductible amounts may be different than yours.



OUT-OF-AREA DEPENDENTS

Benefit Summary	UHC Out-of-Area Signature Value HMO \$20-\$30	UMR Out-of-Area PPO 80/50	
		In Network	Out of Network
Deductible (individual/family)	None	\$500/\$1,000	\$1,000/\$2,000
Medical Plan Out-of-Pocket Maximum (individual/family)	\$5,000/\$15,000	\$5,000/\$10,000	\$6,000/\$12,000
RX Plan Out-of-Pocket Maximum (individual/family)	\$1,600/\$3,200	\$1,600/\$3,200	\$1,600/\$3,200
Health Reimbursement Account	None	None	None
PCP Office Visit	\$20 copay	\$20 copay	50% coinsurance (after deductible)
Specialist Office Visit	\$30 copay	\$40 copay	50% coinsurance (after deductible)
Preventive Care	No charge	No charge	No coverage for non-network services
Inpatient Hospital Care	\$500 copay per admit	20% coinsurance (after deductible)	50% coinsurance (after deductible)
Mental Health Services (outpatient/inpatient)	\$20 copay/\$250 copay	\$20 copay/20% coinsurance (after deductible)	50% coinsurance (after deductible)
Substance Abuse Services (outpatient/inpatient)	No Charge	\$20 copay/20% coinsurance (after deductible)	50% coinsurance (after deductible)
Infertility	Not covered	Not covered	Not covered
Outpatient Diagnostic Laboratory and Radiology (standard procedures)	No charge	No charge	50% coinsurance (after deductible)
Complex Radiology (PET & MRI)	\$200 copay	20% coinsurance (after deductible)	50% coinsurance (after deductible)
Outpatient Surgery	\$100 copay	20% coinsurance (after deductible)	50% coinsurance (after deductible)
Outpatient Physical/Rehab. Therapy (PCP/Specialist)	\$20 copay	\$20 copay	50% coinsurance (after deductible)
Urgent Care (your medical group/other medical group)	\$20 copay/\$50 copay	\$50 copay	50% coinsurance (after deductible)
Emergency Room (copay waived if admitted)	\$100 copay	\$100 copay	\$100 copay
Retail Prescription Drugs (generic/preferred brand/non-preferred brand)	\$15/\$25/50%*	\$10/\$20/\$35 (up to a 30-day supply)	Retail: with submission of a paper claim, member will be reimbursed at the rate the Plan would have paid had the member used an in-network pharmacy less the member's copay.
Mail Order Prescription Drugs (generic/preferred brand/non-preferred brand)	\$30/\$50/50%**	\$20/\$40/\$60 (90 day supply)	No coverage for non-network pharmacy
Chiropractor Services¹	\$20 copay	\$20 copay	50% coinsurance (after deductible)

¹Services must be medically necessary and may be subject to prior authorization from OptumHealth

*\$40 minimum and \$175 maximum

**\$80 minimum and \$350 maximum

Disclaimer: Prepared by Gallagher Benefit Services, Inc. on behalf of VEBA.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to your Human Resources/Benefits Department.

