Your Benefits Resources™

Rockwell Automation

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Medical Coverage Details

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Plan Type Descriptions

Plan Facts	United Healthcare PPO
Disclaimer	Note: Not all covered services, exclusions, and limits are shown in this brief comparison. The contracts and plan documents govern in all cases.
Web site	myuhc.com
Member services	1-866-627-7804; includes Nurseline (24 hours)
Find a network provider	Find a Doctor or Hospital
Group ID	268796

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Cost	United Healthcare PPO
Health Reimbursement Arrangement--Account Information	
HRA--You only	Not applicable
HRA--You and spouse	Not applicable
HRA--You and Child(ren)	Not applicable
HRA--You and family	Not applicable
HRA--Eligible expenses for reimbursement	Not applicable
Health Reimbursement Account Web site	Not applicable
General Medical Expenses	
Annual deductible: Individual/Family	**In Network** You only: $350; You + spouse: $525; You + child(ren): $525; You + family: $700 **Out of Network** You only: $1,050; You + spouse: $1,575; You + child(ren): $1,575; You + family: $2,100
Coinsurance percentage	**In Network** 80% covered; of negotiated charges **Out of Network** 60% covered; subject to Reasonable and Customary limits
Primary doctor office visit	**In Network** 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
Specialist office visit	**In Network** 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to

	Reasonable and Customary limits
Out-of-pocket maximum: Individual/Family	**In Network** You only: $1,750; You + spouse: $2,625; You + child(ren): $2,625; You + family: $3,500 **Out of Network** You only: $3,750; You + spouse: $5,625; You + child(ren): $5,625; You + family: $7,500
Lifetime coverage limit	**In Network** $3,000,000; in and out-of-network combined **Out of Network** $3,000,000; in and out-of-network combined
Inpatient Hospital Care	
Hospital copay	**In Network** Not applicable **Out of Network** Not applicable
Hospital semi-private room	**In Network** 80% covered after plan deductible; preauthorization required **Out of Network** 60% covered after plan deductible; preauthorization required; subject to Reasonable and Customary limits
Inpatient lab and X-ray	**In Network** 80% covered; after plan deductible **Out of Network** 60% covered; after plan deductible; subject to Reasonable and Customary limits
Inpatient physician and surgeon services	**In Network** 80% covered; after plan deductible **Out of Network** 60% covered; after plan deductible; subject to Reasonable and Customary limits
Outpatient Care	
Outpatient surgery	**In Network** 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
Outpatient laboratory services	**In Network** 80% covered after deductible is met; 100% covered at LabCard facilities for blood, urine and pathology services; www.labcard.com, 1-800-646-7788 **Out of Network** 60% covered after deductible is met; subject to Reasonable & Customary limits; 100% covered at LabCard facilities for blood, urine and pathology services; www.labcard.com, 1-800-646-7788
Outpatient X-ray	**In Network** 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
Emergency room (not followed by admission)	**In Network** 80% covered after deductible is met; preauthorization required upon admission; 50% covered after deductible is met non-emergency use **Out of Network** 80% covered after deductible is met; preauthorization required upon admission; 50% covered after deductible is met non-emergency use; subject to Reasonable and Customary limits

Urgent care clinic visit	**In Network** 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
Prescription Drug Expenses	
Prescription drug vendor	Caremark
Prescription drug Web site	caremark.com
Prescription drug member services	1-866-768-4254
Annual prescription deductible	Not applicable
Annual Rx out-of-pocket maximum	$2,000; does not apply to medical plan out-of-pocket maximum
Retail generic	75% covered; $7.50 minimum; $75 per script maximum; 30 day supply
Retail formulary brand	75% covered; $15 minimum; $75 per script maximum; 30 day supply
Retail nonformulary brand	50% covered; $35 minimum; $75 per script maximum; 30 day supply
Mail order generic	75% covered; $15 minimum; $150 per script maximum; 90 day supply
Mail order formulary brand	75% covered; $30 minimum; $150 per script maximum; 90 day supply
Mail order nonformulary brand	50% covered; $70 minimum; $150 per script maximum; 90 day supply
Oral contraceptives	Retail and mail order available

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Coverage	**United Healthcare PPO**
Adult Preventive Care	
Annual physical exam	**In Network** 100% covered; limited to $300 per year for all preventive services combined; then 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
Well-woman exam (includes pap)	**In Network** 100% covered; limited to $300 per year for all preventive services combined; then 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
Mammogram	**In Network** 100% covered; limited to $300 per year for all preventive services combined; then 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
Cancer screenings	**In Network** 100% covered; limited to $300 per year for all preventive services combined; then 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
Cardiovascular screenings	**In Network** 100% covered; limited to $300 per year for all preventive services combined; then 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits

Allergy tests and treatments	**In Network** 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
Family Planning	
Fertility drugs	Not covered
Fertility services	**In Network** 80% covered after deductible is met; limited to diagnosis and treatment of the underlying cause of infertility; GIFT and ZIFT not covered **Out of Network** 60% covered after ded; limited to diagnosis and treatment of the underlying cause of infertility; GIFT and ZIFT not covered; subject to R&C limits
Artificial insemination	**In Network** Not covered **Out of Network** Not covered
In vitro fertilization	**In Network** Not covered **Out of Network** Not covered
Female tubal ligation	**In Network** 80% covered after deductible is met; reversals not covered **Out of Network** 60% covered after deductible is met; reversals not covered; subject to Reasonable and Customary limits
Male vasectomy	**In Network** 80% covered after deductible is met; reversals not covered **Out of Network** 60% covered after deductible is met; reversals not covered; subject to Reasonable and Customary limits
Maternity Care	
Office visit: Pre/postnatal	**In Network** 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
In-hospital delivery services	**In Network** 80% covered after deductible is met; preauthorization required **Out of Network** 60% covered after deductible is met; preauthorization required; subject to Reasonable and Customary limits
Newborn nursery services	**In Network** 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
Prenatal care management	Yes; through UnitedHealthcare
Well-Baby/Well-Child Preventive Care	
Pediatric exams	**In Network** 100% covered; limited to $300 per year for all preventive services combined; then 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits

Immunizations (child)	**In Network** 100% covered; limited to $300 per year for all preventive services combined; then 80% covered after deductible is met **Out of Network** 60% covered after deductible is met; subject to Reasonable and Customary limits
Mental Health Care	
Mental Health: Combined with substance abuse	**In Network** Preauthorization required by ValueOptions for mental health & substance abuse services; www.achievesolutions.net, 1-800-892-1415 **Out of Network** Preauthorization required by ValueOptions for mental health & substance abuse services; www.achievesolutions.net, 1-800-892-1415
Mental Health: Outpatient coverage	**In Network** $15 copay **Out of Network** 50% covered; separate $250 deductible applies combined with inpatient; subject to Reasonable and Customary limits
Mental Health: Inpatient coverage	**In Network** 80% covered **Out of Network** 50% covered; separate $250 deductible applies combined with outpatient; subject to Reasonable and Customary limits
Substance Abuse Care	
Detox: Outpatient coverage	**In Network** $15 copay; limited to 30 visits per year; two substance abuse episodes per lifetime; in and out-of-network combined **Out of Network** 50% covered; limited to 30 visits per year; two substance abuse episodes per lifetime; in & out-of-network combined; separate $250 ded applies combined w/inpatient; subject to R&C limits
Detox: Inpatient coverage	**In Network** 80% covered; limited to 30 days per year; two substance abuse episodes per lifetime **Out of Network** 50% covered; limited to 30 days per year; two substance abuse episodes per lifetime; separate $250 deductible applies combined with outpatient; subject to R&C limits
Rehab: Outpatient coverage	**In Network** $15 copay; limited to 30 visits per year; two substance abuse episodes per lifetime; in and out-of-network combined **Out of Network** 50% covered; limited to 30 visits per year; two substance abuse episodes per lifetime; in & out-of-network combined; separate $250 ded applies combined w/inpatient; subject to R&C limits
Rehab: Inpatient coverage	**In Network** 80% covered; limited to 30 days per year; two substance abuse episodes per lifetime **Out of Network** 50% covered; limited to 30 days per year; two substance abuse episodes per lifetime; separate $250 deductible applies combined with outpatient; subject to R&C limits
Dental Care	

Dental implants	**In Network** Not covered **Out of Network** Not covered
Accidental injury to teeth	**In Network** 80% covered after deductible is met; ltd to treatment of natural teeth; services must be completed within the year of accident or the year following **Out of Network** 60% cov after ded; ltd to treatment of natural teeth; services must be completed within the year of accident or the year following; subj to R&C limits
Surgical removal of tumors and cysts	**In Network** 80% covered after deductible is met; limitations apply; check with Plan for details **Out of Network** 60% covered after deductible is met; limitations apply; check with Plan for details; subject to Reasonable and Customary limits
Vision Care	
Routine vision exams	**In Network** Vision Discount Plan through VSP; call toll free 1-800-877-7195 for details **Out of Network** Not covered
Regular lenses and frames	**In Network** Vision Discount Plan through VSP; call toll free 1-800-877-7195 for details **Out of Network** Not covered
Contact lenses	**In Network** Vision Discount Plan through VSP; call toll free 1-800-877-7195 for details **Out of Network** Not covered
Other Services	
Ambulance services	80% covered after deductible is met; must be a true emergency
Durable medical equipment	**In Network** 80% covered after deductible is met; preauthorization required for expenses over $1,000 **Out of Network** 60% covered after deductible is met; preauthorization required for non-participating provider and expenses over $1,000; subject to Reasonable and Customary limits
Hearing Care	
Hearing evaluations	**In Network** 80% covered after deductible is met; audiometric exam and hearing aid evaluation test; limited to one exam every 36 months **Out of Network** 60% covered after deductible is met; audiometric exam and hearing aid evaluation test; limited to one exam every 36 months; subject to R&C limits
Hearing aids	**In Network** 80% covered; limited to $750 per ear every 36 months **Out of Network** 60% covered; limited to $750 per ear every 36 months; subject to Reasonable and Customary limits
Medical Therapy	

Acupuncture	**In Network** 80% covered after deductible is met; performed in lieu of anesthesia in connection with surgery **Out of Network** 60% covered after deductible is met; performed in lieu of anesthesia in connection with surgery; subject to Reasonable and Customary limits
Chiropractic	**In Network** 80% covered after deductible is met; limited to 25 visits per year **Out of Network** 60% covered after deductible is met; limited to 25 visits per year; subject to Reasonable and Customary limits
Outpatient physical therapy	**In Network** 80% covered after deductible is met; review for medical necessity required after 20 visits **Out of Network** 60% covered after deductible is met; review for medical necessity required after 20 visits; subject to Reasonable and Customary limits
Outpatient speech therapy	**In Network** 80% covered after deductible is met; limited to 60 visits per year; review for medical necessity required after 20 visits **Out of Network** 60% covered after deductible is met; limited to 60 visits per year; review for medical necessity required after 20 visits; subject to Reasonable and Customary limits
Outpatient occupational therapy	**In Network** 80% covered after deductible is met; review for medical necessity required after 20 visits **Out of Network** 60% covered after deductible is met; review for medical necessity required after 20 visits; subject to Reasonable and Customary limits
Care at Alternate Sites	
Noncustodial home health care	**In Network** 100% covered after deductible is met; limited to 120 visits per year; preauthorization required **Out of Network** 60% covered after deductible is met; limited to 120 visits per year; preauthorization required; subject to Reasonable and Customary limits
Prescribed care in noncustodial skilled nursing facility	**In Network** 80% covered after deductible is met; limited to 90 days per year; in and out-of-network combined; preauthorization required **Out of Network** 60% covered after deductible is met; limited to 90 days per year; in and out-of-network combined; preauthorization required; subject to Reasonable and Customary limits
Hospice care	**In Network** 100% covered after deductible is met; preauthorization required **Out of Network** 60% covered after deductible is met; preauthorization required; subject to Reasonable and Customary limits

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Access	**United Healthcare PPO**
Out-of-area dependent coverage	Yes
Out-of-area participant coverage	Yes

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Ease of Use	United Healthcare PPO
Need to file claims	**In Network** No **Out of Network** Yes
Number of PCP changes allowed/year	Not Applicable
Ability to self-refer to OB/GYN	Yes
Ability to self-refer to specialists	Yes

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Member Satisfaction	United Healthcare PPO
% satisfied with plan overall	
Health plan average	Not Available
National average	84%
% satisfied with quality of care provided	
Health plan average	Not Available
National average	96%
% satisfied with plan's convenience/ease of use	
Health plan average	Not Available
National average	89%
% satisfied with types of services covered	
Health plan average	Not Available
National average	85%

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Special Care Management Education and Assistance Programs	United Healthcare PPO
Asthma care management	Yes; through CareAllies, call toll free 1-877-245-2433
Cancer care management	Not applicable
Diabetes care management	Yes; through CareAllies, call toll free 1-877-245-2433
Heart disease care management	Yes; through CareAllies, call toll free 1-877-245-2433
Chronic Obstructed Pulmonary Disease	Yes; through CareAllies, call toll free 1-877-245-2433
Hypertension care management	Not applicable
Smoking cessation program	Not applicable
Weight control program	Not applicable
Disclaimer	Note: Not all covered services, exclusions, and limits are shown in this brief comparison. The contracts and plan documents govern in all cases.

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The comparison charts are compiled using information that applies to a large number of health plan users and is commonly reported by the health plans. Depending on the chart type, such as charts for dental and vision plans, certain information and/or sections won't appear because the necessary data isn't available. If you have questions about a topic that isn't covered in the charts, contact the plan's member services department for additional information. Also, keep in mind that the information on access and quality of care is provided by the health plans. Neither Rockwell Automation nor Hewitt Associates is responsible for the accuracy of this information. If there is a discrepancy between the information displayed on these charts and the official plan documents, the official plan documents will control. Rockwell Automation reserves the right to amend, suspend, or terminate the plan(s) or program(s) at any time. The Member Satisfaction information above is provided by the Hewitt Satisfaction Survey. If an insufficient number of individuals responded for a particular plan, that plan won't be reported.