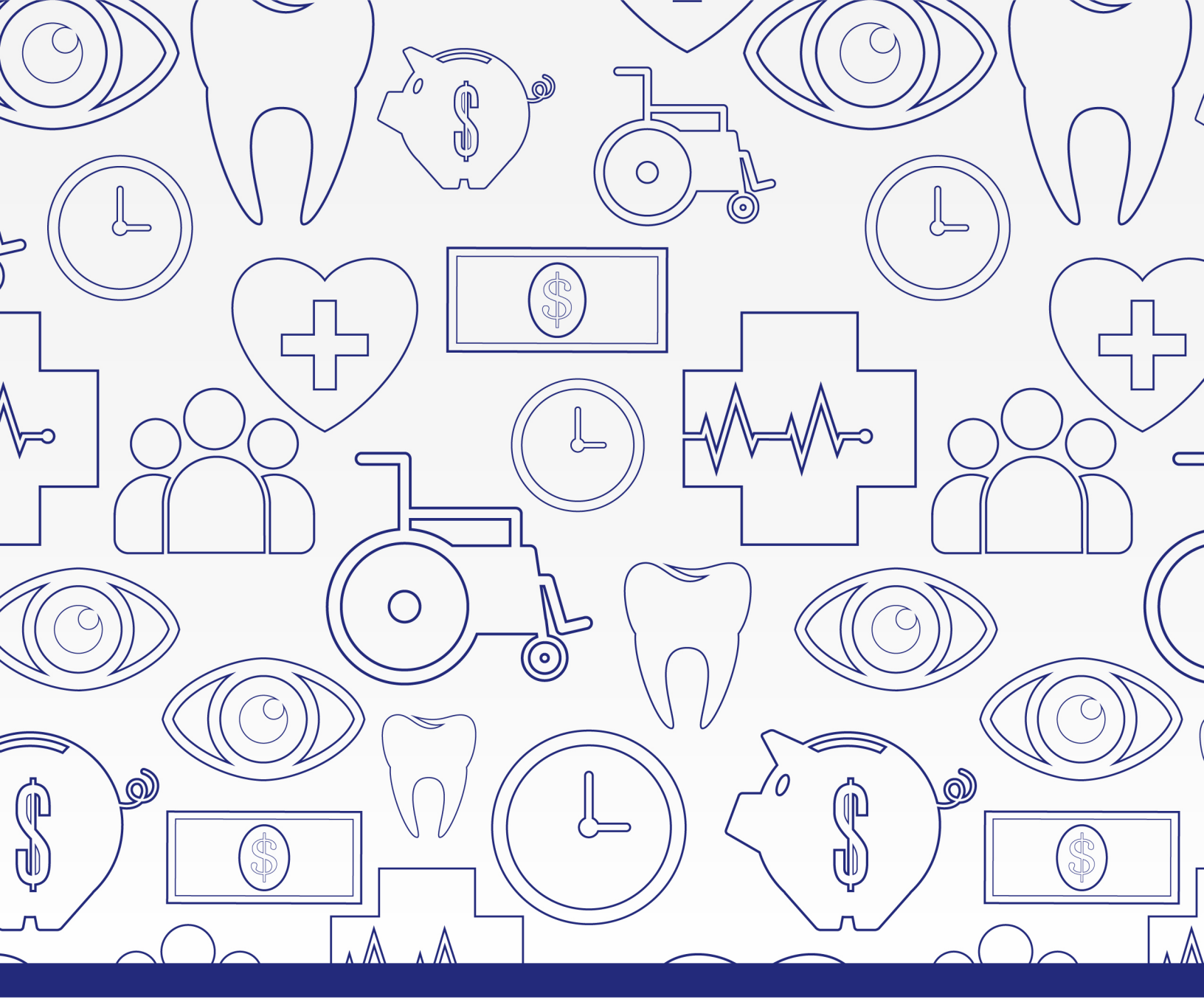

WELCOME TO OPEN ENROLLMENT

Plan Year: October 1, 2021 – September 30, 2022

HUB

THE CITY OF EVERMAN TEXAS

Wellspring Insurance Agency, Inc.

PICK THE BEST BENEFITS FOR YOU AND YOUR FAMILY.

The City of Everman strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Open Enrollment Guide.

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all the different benefits The City of Everman offers, so you can identify which offerings are best for you and your family.

Elections you make during open enrollment will become effective on October 1, 2021. If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to HR.

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Welcome to
Open Enrollment

THE CITY OF EVERMAN

WHO IS ELIGIBLE?

If you're a full-time employee at The City of Everman, you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week. In addition, the following family members are eligible for medical, dental, and vision coverage:

- Spouse & Child(ren)
- All Part Time employees will receive the New Benefits policy

HOW TO ENROLL

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully. After you receive the email from the city you can go to www.hrconnection.com and make your elections.

WHEN TO ENROLL

Open enrollment begins on **September 9, 2021** and runs through **September 17, 2021.** The benefits you choose during open enrollment will become effective on **October 1, 2021**.

If you are a new hire, you are available for coverage the **1st day of the month following your date of hire**.

HOW TO MAKE CHANGES

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

NEW- UHC MEDICAL INSURANCE

The City of Everman contributes 100% to the Employee Only cost ($798.62) for BCYB Base Plan. The Employee can choose to participate in any one of the four plans referenced in chart above. Employees are eligible to enroll qualified Spouses and Dependents. The cost will be deducted via payroll deduction on a pre-tax basis. Employees who opt out completely out of medical insurance will receive a $250 stipend a month. You must provide proof of other coverage to receive the stipend.

Services	UHC NAVIGATE BCXO HMO	UHC AE3K HSA PPO	UHC BCZS EPO	BASE PLAN UHC BCYB PPO
Physician Visit Specialist Visit	$25 Copay $75 Copay	100% after deductible 100% after deductible	$30 Copay $60 Copay	$20 Copay $40 Copay
PCP Required/Referral	Yes	No	No	No
PCP Visit < age 19	$0	100% after deductible	$0	$0
Designated Specialist Visit	$75 Copay	100% after deductible	$30 Copay	$20 Copay
Member Coinsurance (in|out)	80% | 0%	100% | 70%	100% | 0%	80% | 50%
Urgent Care	$100 Copay	100% after deductible	$75 Copay	$75 Copay
Deductible - Individual - Family	 $1,000 $2,000	 $3,000 $6,000	 $3,000 $6,000	 $250 $500
Hospitalization	80% After Deductible	100% after deductible	100% After Deductible	80% After Deductible
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Emergency Room	$500 Copay	100% after deductible	$300 Copay	80% after $250 Copay
Out-of-Pocket Max - Individual - Family	(Includes Deductible) $6,600 $13,200	(Includes Deductible) $4,000 $8,000	(Includes Deductible) $4,500 $9,000	(Includes Deductible) $3,000 $6,000
Prescription Drugs - Generic - Preferred - Non-Preferred	 $10 copay $35 copay $85 copay	 $10 copay after deductible $35 copay after deductible $85 copay after deductible	 $10 copay $35 copay $85 copay	 $10 copay $35 copay $85 copay

AE3K HSA- if employee only coverage is selected the City will contribute $300.00 per month into the HSA for eligible participants. If dependent coverage is selected the full $1,000.00 will be applied toward the cost of premium and no contribution will be made to the HSA.

Any employee covering dependents will get the full $1,000 towards their premiums as well. The rates below already have the $1,000 deducted from them.

YOUR MEDICAL COST

EMPLOYEE SEMI-MONTHLY PAYROLL DEDUCTIONS (EFFECTIVE OCTOBER 1, 2021)				
Semi-Monthly Cost	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
UHC BCXO HMO	$0.00	$53.78	$53.78	$330.68
UHC AE3K HSA PPO	$0.00	$162.27	$162.27	$493.41
UHC BCZS EPO	$0.00	$197.02	$197.02	$545.54
BASE PLAN UHC BYCB	$0.00	$298.62	$298.62	$697.94

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact HR.

Digital Support | UnitedHealthcare app

Get on-the-go access to your health plan.

The UnitedHealthcare® app puts your plan at your fingertips.

When you're out and about, you can do everything from managing your plan to getting convenient care. Just download the app to:

- Find nearby care options in your network.
- Estimate costs.
- Video chat with a doctor 24/7.*
- View and share your health plan ID card.
- See your claim details and view progress toward your deductible.

Get the app and log on with Touch ID®.

The UnitedHealthcare app is available for download for iPhone® or Android®.

United Healthcare

HEALTH SAVINGS ACCOUNTS

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

WHAT ARE THE BENEFITS OF AN HSA?

There are many benefits of using an HSA, including the following:

- **It saves you money.** HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.
- **It is portable.** The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
- **It is a tax-saver**—HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

The maximum amount that you can contribute to an HSA in 2021 is $3,600 for individual coverage and $7,200 for family coverage.

Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

HSA CASE STUDY

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan's annual deductible is $1,500 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. (This example only includes HSA contribution amounts and does not reflect any investment earnings.)

Year 1	
HSA Balance	$1,000
Total Expenses: - Prescription drugs: $150	(-$150)
HSA Rollover to Year 2	$850
Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

→

Year 2	
HSA Balance	$1,850
Total Expenses: - Office visits: $100 - Prescription drugs: $200 - Preventive care services: $0 (covered by insurance)	(-$300)
HSA Rollover to Year 3	$1,550
Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

Welcome to
Open Enrollment

THE CITY OF EVERMAN

NEW MUTUAL OF OMAHA DENTAL INSURANCE

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings, and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

The City of Everman will pay 100% of the Employee Only cost. All cost associated with adding spouses and/or dependents will be the responsibility of the employee and deducted via pre-tax payroll deduction. For those that provide this coverage to eligible spouse and dependents the cost has been reduced!

To look up providers, please visit www.mutualofomaha/dental.com

TYPE OF SERVICE	AMOUNT YOU PAY
Preventive Services	Exams, cleanings, X-rays— 100% Coinsurance
Deductible	Applies to basic and major services only— $50 Individual / $150 Family
Basic Services	Fillings, Stainless Steel Crowns—80% Coinsurance
Major Services	Root Canal, Crowns, Dentures, Anesthesia/Sedation— 50% Coinsurance
Annual Maximum	$2,000 (Preventative does not accumulate towards Annual Limit)
Child Ortho	50% up to $1,500 Lifetime Maximum
Out of Network Reimbursement	90th% Usual, Customary & Reasonable Charges
Semi-Monthly Payroll Deductions	Employee only—$0.00 Employee & 1 Dependent—$18.50 Employee & Family—$36.52

Dental Insurance

Online Reference Guide for Plan Members

You have a great dental plan – now learn how to make full use of it to ensure proper dental health for you and your family.

With online access you can:

1. View benefits information, eligibility and claims
2. Print or view Explanation of Benefits (EOBs)
3. Print, view or request ID cards
4. Locate a provider, by ZIP code or address

Getting Started

1. Go to MutualofOmaha.com/dental
2. Click on the "Member Portal Link" and select the "Register Now" button. You will enter your Member ID number (located on your member ID card) or the last 4 digits of your Social Security Number and follow the instructions to create your user name and password.

Visit as many times as you need to view or print copies of your coverage information.
Note: Due to HIPAA a spouse and adult child will have to register separately.

Logging On

1. Go to **MutualofOmaha.com/dental**
2. Enter your username and password
3. Click the "Login" button

Online Tools

This section provides you with an overview of your access to benefits information including:

- View your coverage information and eligibility
- Individuals included under your plan
- Access to view, print or request an ID card
- After you've visited the dentist, use the "Claims" tab to find historical claim data
- View or print your Explanation of Benefits (EOB) from the "Documents" tab

Access a Claim Form

If you visit an out-of-network provider, you can download a claim form from the home page.

Locate a Provider Two Ways

You have complete freedom to select a provider of your choice, either in network or out of network. You can access the provider search two ways! From the home page, use the Provider Quick Search tool to locate a provider by using your ZIP code or address. You also have access to a provider search page after you log into the Member Portal via the "Providers" tab.

Customer Service

800-927-9197

Mutually Preferred®

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

SUPERIOR VISION INSURANCE

The City of Everman's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

The City of Everman will contribute 100% of the Employee Only cost of plan. All cost associated with adding spouses and/or dependents will be the responsibility of the employee and deducted via pre-tax payroll deduction.

To search for participating providers please visit www.SuperiorVision.com.

TYPE OF SERVICE	AMOUNT YOU PAY
Eye Exam	$10 copay
Materials/Eyewear	$25 copay
Standard Corrective Lens - Single - Lined Bifocal - Lined Trifocal	Covered under Materials copay
Contact Lenses	Covered under Materials copay
Frame Allowance	$100 Allowance once every 24 months from date of service
Contact Lens Allowance	$125 Allowance once every 12 months from date of service
Semi-Monthly Payroll Deductions	Employee only—$0.00 Employee & spouse—$2.16 Employee & child(ren)—$2.46 Family—$5.03

SuperiorVision™

Download our mobile app

Create an online account

- Log in with the username and password you use to access your Member account on SuperiorVision.com
- Or, you can create an account in the app.

Locate a provider

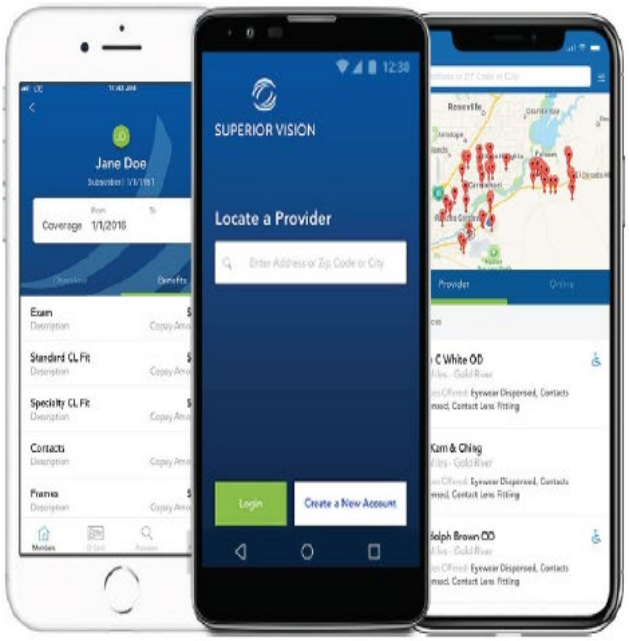
- Find a provider in your network
- Get directions
- Call the provider

View your vision benefits

- Review your vision benefits and the benefits for any dependents

Get your member ID card

- View our ID card full screen
- Print or email your ID card



Download on the App Store

GET IT ON Google Play

NEW-MUTUAL OF OMAHA BASIC LIFE INSURANCE

Life insurance can help provide for your loved ones if something where to happen to you. The City of Everman provides full-time employees with up to 2x salary, not to exceed $300,000, for Basic Life and accidental death and dismemberment (AD&D) insurance. The City of Everman pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums.

Don't Forget to Update your Beneficiaries in HRConnect.

You can update these anytime during the year, you do not need a life event to update Beneficiaries.

Open Enrollment is the Perfect time to check!

NEW-MUTUAL OF OMAHA VOLUNTARY LIFE INSURANCE

Employees who wish to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through Semi-Monthly payroll deductions. Coverage available:

There is a True Open enrollment for Voluntary Life. You may elect all the way up to the GI without having to complete the EOI. If you wish to apply for coverage after your original date of eligibility health questions are required to be considered for coverage.

Employee: increments of $10,000 to a maximum of $300,000 not to exceed 5 times your earnings. *Amounts above $100,000 will be subject to additional underwriting.*

Spouse: increments of $5,000 to a maximum of $150,000 not to exceed 100% of employee election. *Amounts above $25,000 will be subject to additional underwriting.*

Child(ren): you may elect $10,000. The amount may not exceed 50% of employee election. *Child(ren) are covered until Age 26.*

You must enroll in Voluntary Life Coverage for yourself, to be eligible to enroll your spouse or dependents.

Voluntary Term Life and AD&D Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life and AD&D section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

EMPLOYEE PREMIUM TABLE (24 PAYROLL DEDUCTIONS PER YEAR)

Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0 - 34	$0.63	$1.26	$1.89	$2.52	$3.15	$3.78	$4.41	$5.04	$5.67	$6.30
35 - 39	$0.81	$1.62	$2.43	$3.24	$4.05	$4.86	$5.67	$6.48	$7.29	$8.10
40 - 44	$1.12	$2.23	$3.35	$4.46	$5.58	$6.69	$7.81	$8.92	$10.04	$11.15
45 - 49	$1.74	$3.47	$5.21	$6.94	$8.68	$10.41	$12.15	$13.88	$15.62	$17.35
50 - 54	$2.75	$5.50	$8.25	$11.00	$13.75	$16.50	$19.25	$22.00	$24.75	$27.50
55 - 59	$4.52	$9.03	$13.55	$18.06	$22.58	$27.09	$31.61	$36.12	$40.64	$45.15
60 - 64	$6.59	$13.18	$19.77	$26.36	$32.95	$39.54	$46.13	$52.72	$59.31	$65.90
65 - 69	$10.87	$21.74	$32.61	$43.48	$54.35	$65.22	$76.09	$86.96	$97.83	$108.70
70 - 74	$18.95	$37.89	$56.84	$75.78	$94.73	$113.67	$132.62	$151.56	$170.51	$189.45
75 - 79	$31.61	$63.22	$94.83	$126.44	$158.05	$189.66	$221.27	$252.88	$284.49	$316.10
80 - 84	$50.01	$100.02	$150.03	$200.04	$250.05	$300.06	$350.07	$400.08	$450.09	$500.10
85 - 89	$75.34	$150.68	$226.02	$301.36	$376.70	$452.04	$527.38	$602.72	$678.06	$753.40
90+	$108.75	$217.50	$326.25	$435.00	$543.75	$652.50	$761.25	$870.00	$978.75	$1,087.50

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (24 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 34	$0.30	$0.60	$0.90	$1.19	$1.49	$1.79	$2.09	$2.38	$2.68	$2.98
35 - 39	$0.39	$0.78	$1.17	$1.55	$1.94	$2.33	$2.72	$3.10	$3.49	$3.88
40 - 44	$0.54	$1.08	$1.62	$2.16	$2.70	$3.24	$3.78	$4.32	$4.86	$5.40
45 - 49	$0.85	$1.70	$2.55	$3.40	$4.25	$5.10	$5.95	$6.80	$7.65	$8.50
50 - 54	$1.36	$2.72	$4.08	$5.43	$6.79	$8.15	$9.51	$10.86	$12.22	$13.58
55 - 59	$2.24	$4.48	$6.72	$8.96	$11.20	$13.44	$15.68	$17.92	$20.16	$22.40
60 - 64	$3.28	$6.56	$9.84	$13.11	$16.39	$19.67	$22.95	$26.22	$29.50	$32.78
65 - 69	$5.42	$10.84	$16.26	$21.67	$27.09	$32.51	$37.93	$43.34	$48.76	$54.18
70 - 74	$9.46	$18.91	$28.37	$37.82	$47.28	$56.73	$66.19	$75.64	$85.10	$94.55
75 - 79	$15.79	$31.58	$47.37	$63.15	$78.94	$94.73	$110.52	$126.30	$142.09	$157.88
80 - 84	$24.99	$49.98	$74.97	$99.95	$124.94	$149.93	$174.92	$199.90	$224.89	$249.88
85 - 89	$37.66	$75.31	$112.96	$150.61	$188.27	$225.92	$263.57	$301.22	$338.88	$376.53
90+	$54.36	$108.72	$163.08	$217.43	$271.79	$326.15	$380.51	$434.86	$489.22	$543.58

ALL CHILDREN PREMIUM TABLE (24 PAYROLL DEDUCTIONS PER YEAR)*

$1,000	$2,000	$3,000	$4,000	$5,000	$6,000	$7,000	$8,000	$9,000	$10,000
$0.15	$0.30	$0.45	$0.60	$0.75	$0.90	$1.05	$1.20	$1.35	$1.50

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.

NEW-MUTUAL OF OMAHA SHORT-TERM DISABILITY

The City is providing all eligible full-time employees a Short -Term Disability policy. The cost of the policy is paid for by the City.

Weekly Benefit Amount = 60% of pre-disability earning not to exceed $1,500
Elimination Period = 14th day accident/ 14th day sickness
Benefit Duration = 11 weeks

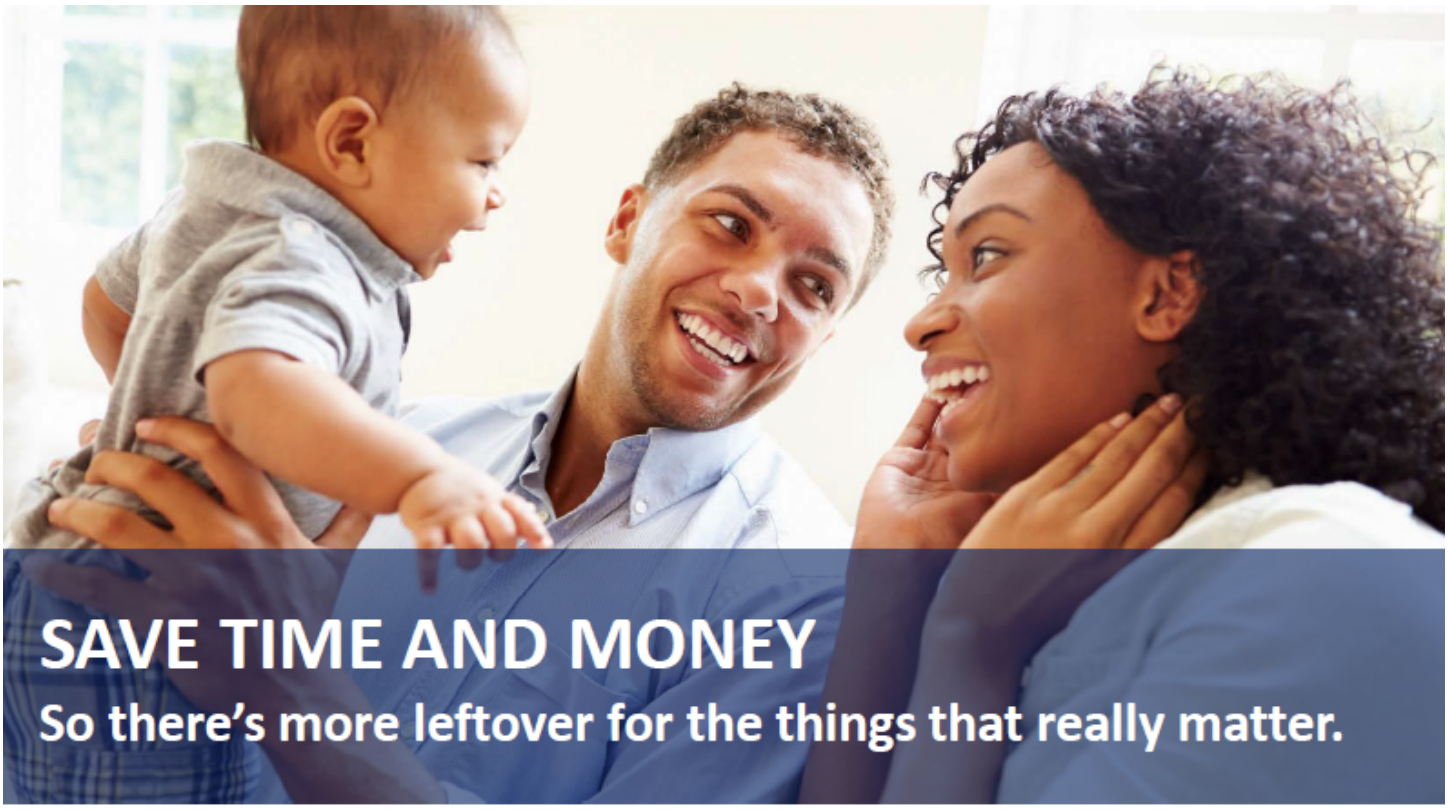
NEW-MUTUAL OF OMAHA LONG-TERM DISABILITY

In the event that you remain disabled and unable to work after 26 weeks the City is also providing all eligible full-time employees a Long- Term Disability policy, this is also paid by the City.

Monthly Benefit Amount = 60% of pre-disability earnings not to exceed $5,000
Elimination Period = 90 days or until the end of the STD Maximum Benefit
Benefit Duration = (SSNRA) Social Security Normal Retirement Age

NEW BENEFITS

New Benefits is a benefit that is provided free of charge to all full & part time employees. Please see below flyer for more information.



Your employer is giving you access to several convenient benefits. This program includes your immediate family—so everyone is healthy and happy! Click on the benefit names below for additional information, FAQ's, videos, sample savings and to locate providers where applicable!

Teladoc ($0 Visit Fee)
Feel better now! 24/7 access to a doctor is only a call or click away—anytime, anywhere with no per visit fee. You can talk to a doctor by phone or online video to get a diagnosis, treatment options and prescription if medically necessary. Save time and money by avoiding crowded waiting rooms in the doctor's office, urgent care clinic or ER.

Doctors Online
The fast, easy way to get health information from an online resource you can trust. You have 24/7 access to doctors, pharmacists, psychologists, dentists, dieticians and more by email or smartphone app. You'll get treatment options and advice you understand. With Doctors Online, the doctor's always in!

Health Advocate™ Solutions
Personal Health Advocates help you navigate through insurance and healthcare systems. Advocates research treatments, resolve claims and locate doctors, specialists, hospitals, dentists and pharmacies. Skilled negotiators will attempt to negotiate discounts on your behalf, no matter your benefit status. Registered nurses are on-call 24/7 to answer questions and provide medical explanations.

Pharmacy (DST Pharmacy Solutions)
Save 10% to 85% on most prescriptions at 60,000 pharmacies nationwide including CVS, Walgreens, Target and more.

Durable Medical Equipment
Need an easy way to order medical equipment online or by phone? Not only will your supplies ship to you, but you'll save 20% to 50% and an additional $5 on orders over $100! Save on walking aids, wheelchairs, scooters, hospital beds, bathroom safety, orthopedic products and more.

Hearing Aids- Connect Hearing
Want to save big on hearing aids? We hear you! You'll save 35% off the suggested retail price (MSRP) at thousands of retail locations nationwide.

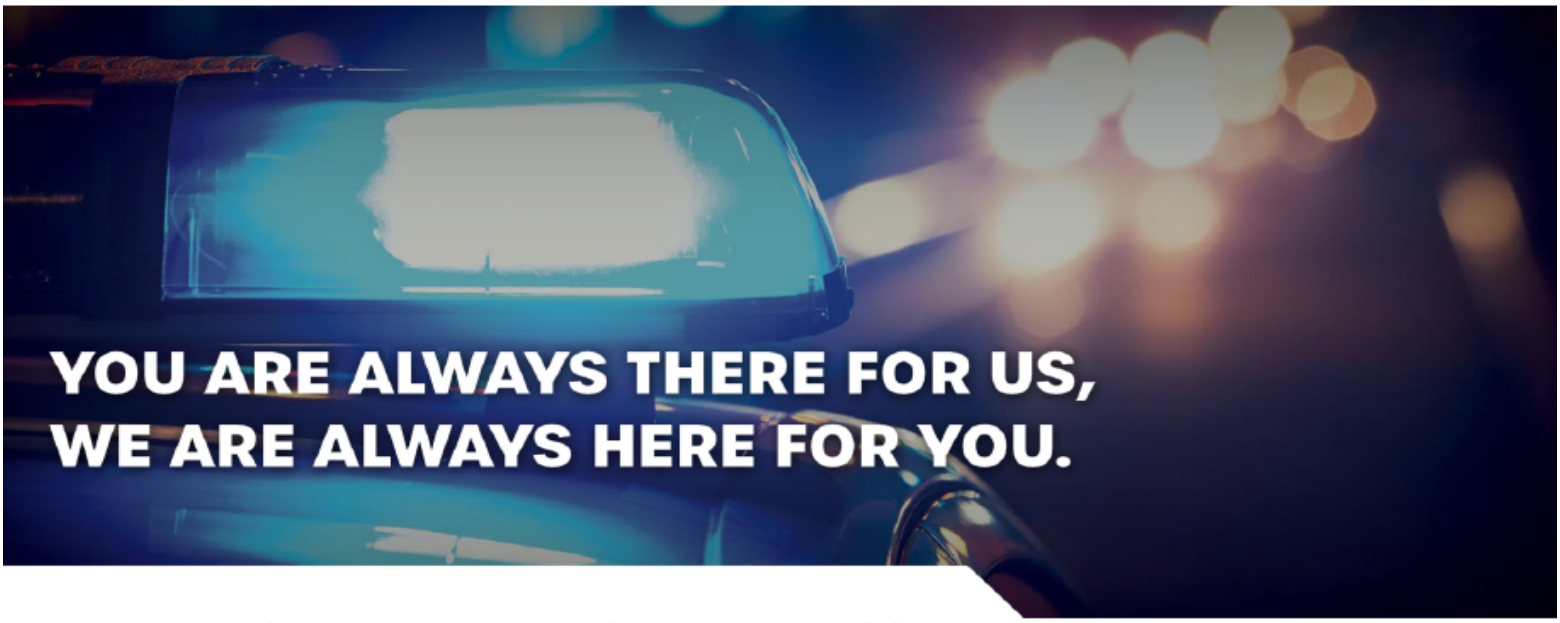
Lab Testing
Know your numbers! You have direct access to major clinical laboratories nationwide where you can save 10% to 80% on typical costs for lab work. Find a location near you and order online or by phone. Confidential results are available online in as little as 24 hours for most tests. *Lab benefit not available in MD, ND, NJ, NY and RI.*

MRI & CT Scans
A better image leads to a better diagnosis, better treatment and a better recovery. Save 40% to 75% on usual charges for MRI and CT Scans at thousands of credentialed radiology centers nationwide.

What to Expect?

- **Membership materials (booklet and ID card) will be mailed to your home address**
- **Your new materials will display your name and member ID**
- **Your membership provides access to 24/7 doctor visits for $0 out of your pocket**
- **You will need to setup a new account with Teladoc – follow the instructions in your member materials or on your member portal www.MyMemberPortal.com**

RESPONDER HEALTH



PREVENTION. INTERVENTION. WELLNESS.

We know asking for help is hard – the last thing you should have to think about is how your insurance pays. That's why Responder Health has partnered with the City of Everman to simplify the process. Whether you need inpatient treatment, help with finding the right counselor, or simply just to talk to someone – we have your back, just like you have ours.

When you need to talk, we are here 24/7 just call 206-459-3020. Your peer advocate will work to find the right solution for you.

PEER TO PEER COUNSELING

- The moment a peer advocate answers your call, they are ready to talk. Sometimes all that's needed is a conversation about a hard day – this completely confidential service is no cost to you.

OUTPATIENT COUNSELING

- If needed, your Peer Advocate from the Hotline will take your contact information and a Peer Counselor from Serve and Protect will call you back within 48-72 hours to help identify your counseling need.
- The Peer Counselor from Serve and Protect will collect your insurance information and work to find a vetted counselor that is accepting new patients.
- You will receive the counselor's contact information for you to call and make an appointment that works with your schedule.

INPATIENT TREATMENT

- If you need inpatient treatment, your Peer Advocate will bring in a clinician/ intake coordinator from the facility to do an assessment over the phone.
- The Peer Advocate will collect your insurance information and the vetted facility will work with insurance to obtain the proper authorization for treatment.
- If you need to fly to the facility, the flight to the facility is the member responsibility. It is not covered by Responder Health.

Health Plans | Navigate | Texas

Getting to know UnitedHealthcare Navigate.

Access preventive and primary care, specialty services, and helpful tools and resources for your journey to healthier.

When you enroll in UnitedHealthcare Navigate®, you'll need to select a network primary care physician (PCP), who will help guide you through the health care system. Your PCP gets to know you, helps manage your health care and refers you to specialists, if needed. Plus, you'll save time and money when you get your care from a network provider.

These questions and answers will help you understand your plan so you can get the most out of your medical benefits.

Why do I need to select a PCP?

When you enroll in the Navigate plan, you must select a PCP from our Navigate network to help you manage your health and get the care you need. Your PCP provides regular and routine care, like annual checkups, and refers you to other network physicians or specialists when additional care is needed. You are required to get an electronic referral from your physician **before** you see another network PCP or specialist. **Without an electronic referral, your costs may be a lot higher or they may not be covered at all.** Check your benefit plan documents for more information.

How do I select a PCP?

You can go to **welcometouhc.com*** and use the physician search tool, available in English and Spanish, to find a PCP in your plan's network. Or you can call Customer Care for help:

For English: 1-855-828-7715
For Spanish: 1-800-940-1508

Each covered family member must select a PCP located in a town or city near where you (the subscriber) live.

Can each covered family member have his or her own PCP?

Yes. You can select one physician for your entire family, or each covered family member may select his or her own physician. Please check with your physician's office before enrolling to confirm that he or she is accepting new patients and if there are any patient age restrictions.

CONTINUED

Find out more about the UnitedHealthcare Navigate plan and network online at **welcometouhc.com.***

Can I select any type of physician as my PCP?

Your PCP must be a general practice physician, family practice physician, pediatrician or internal medicine physician.

Will my PCP be identified on my health plan ID card?

The PCP's name and telephone number will be listed on each family member's health plan ID card. Be sure to check the PCP name on your ID card to ensure it is your intended PCP. If you want to change from the PCP listed on the card, please call the number on your ID card or go to **myuhc.com®.**

Can a covered family member living out of state select a PCP closer to where he or she lives?

No. Family members must choose a PCP in the town or city near where you (the subscriber) live. This includes students going to school out of state, or children living with another parent.

Can I change my PCP after I enroll?

Yes. PCP changes can be made once a month and are effective the first of the following month. Change requests can be submitted on or before the last day of the month. Changes can be made by calling the number on your ID card or by signing in to **myuhc.com.** New health plan ID cards will be issued whenever members change their PCP.

Can I choose to see other PCPs without a referral?

No. It's important that you get an electronic referral from your PCP before you see any other primary care or specialist physician. An electronic referral from your PCP is necessary to receive coverage or the highest level of benefit possible.

What is a referral?

A referral is an approval from your PCP, which is needed before you receive care from another Navigate network physician or health care professional. Your PCP enters your referral electronically. Before you receive additional care, you will be able to view and confirm your referral on **myuhc.com.**

Do I need to complete any paperwork for referrals?

No. All referrals within your Navigate plan are electronic. When you receive a referral through your PCP, he or she will handle the process for you electronically.

Can I view and track my electronic referrals?

After you enroll, you will be able to confirm all of your referrals online at **myuhc.com** > **Physicians & Facilities,** or you can call the number on the ID card if you have questions.

For English: 1-855-828-7715
For Spanish: 1-800-940-1508

Do I need a referral before seeing a specialist?

Yes. It's important that you get an electronic referral from your PCP **before** you see another network physician, including specialists. You should validate that a referral has been entered prior to seeing a network physician or specialist by checking on **myuhc.com** or calling the number on your ID card.

Are there any providers I can see without a referral?

Yes. Referrals are not needed to see the following providers as long as they are in the Navigate network:

- Obstetricians/gynecologists (OB/GYNs)
- Behavioral health or substance use disorder clinicians
- Convenience care clinics
- Urgent care clinics
- Virtual visit provider

Remember: Emergencies are covered anywhere in the world, including non-network hospitals, without a referral. You should validate that a referral has been entered prior to seeing a network physician or specialist by checking on **myuhc.com** or calling the number on the ID card.

What's the difference between "referral" and "prior authorization"?

Referral: A referral is a required approval submitted electronically by your PCP **before** you get care from another network physician or specialist. An electronic referral from your PCP is necessary to receive coverage or the highest level of benefit possible.

Prior authorization: Prior authorization is the process in which UnitedHealthcare reviews certain health care services before they are received to determine if they are medically necessary and eligible for coverage. Prior authorization is required for certain covered health services, as noted in your benefit plan documents. **If you do not get prior authorization before receiving one of these services, your benefit coverage may be reduced. You also may have no coverage if it's determined that the service is not medically necessary.** For information on which services require prior authorization, see your benefit plan documents.

Where can I find information after I enroll?

Once you enroll and register on **myuhc.com,** you can sign in to take advantage of the available tools and resources.

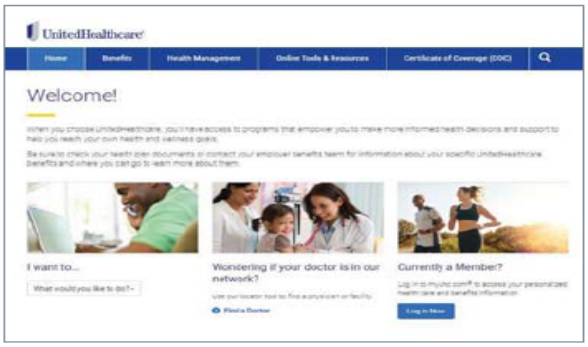
Spanish-speaking members can visit our member website for in-language resources at **uhclatino.com.**

Find your PCP at welcometouhc.com* English and Spanish provider directory.

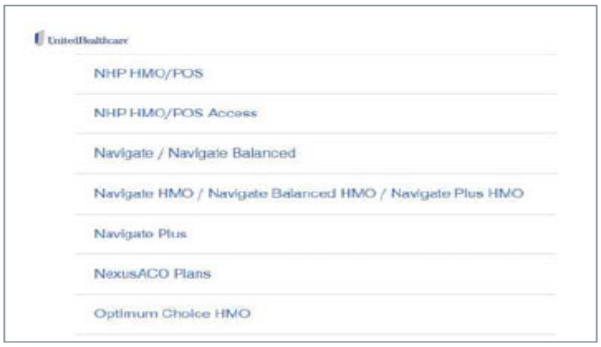
Remember, you need to select a PCP when you enroll in the Navigate plan.

Step 1: Go to **welcometouhc.com.**

Step 2: Select the **Find a Doctor** option.



Step 3: Scroll down and select **Navigate HMO/Navigate Balanced HMO/Navigate Plus HMO** from the network list.



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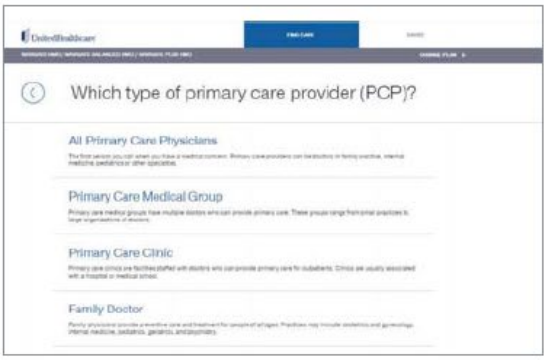
Step 4: Select what year you will receive care.

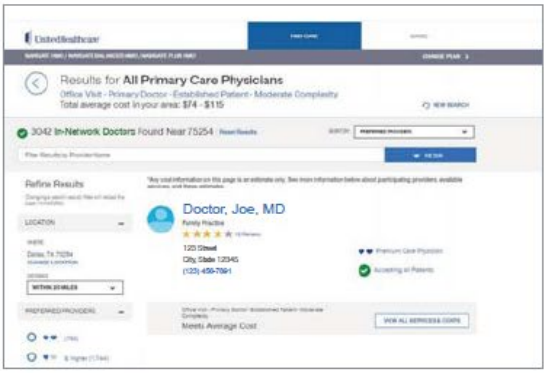
Step 5: Select the **CHANGE LOCATION** option and enter your ZIP code. Then select the **People** tile.

Step 6: Select the **Primary Care** tile.

Step 7: Select **All Primary Care Physicians.**



Step 8: Review your results or refine your search using the prompts on the page.



The **welcometouhc.com** website provides content in English only, but you can access the provider directory in English or Spanish. You can also visit our member website for Spanish-language resources at **uhclatino.com.** If you would prefer to speak to our customer care professionals for assistance, please call:

For English: 1-855-828-7715

For Spanish: 1-800-940-1508

Ready, set, enroll:

- Complete the enrollment form provided by your employer.
- Be sure you include the first and last name for all PCPs selected by you and any covered family members and/or dependents.
- Remember to provide the physician ID number for each PCP listed on the form.

Employee Benefits

Accessing Claims Online Using the Employee Portal

Managing claims shouldn't be difficult. Mutual of Omaha always has our customers in mind, which is why we created our Employee Portal so you can easily access your claims.

Our Employee Portal provides real-time information giving you the ability to view current claims, access claim forms, and submit a new claim for short-term disability benefits.

Getting Started

1. Go to www.mutualofomaha.com/my-benefits.
2. Register for an account by filling out the necessary information. Click on Sign Up.
3. Users will be notified when they have completed the first step of creating an account.
4. An email will be sent with the final steps to finish setting up an account.

Already have an account? Log in with your credentials.

How to View Current Claims

- To access current claims, log in and click on the "Claims" icon*
- View a specific claim and its status, along with the claim number for accident, critical illness and disability.

***PLEASE NOTE:** The "Claims" icon will only be shown if a claim has been filed. If there are no existing claims, the icon will not appear.

Submitting a Claim Form Online

A short-term disability claim form can be submitted online by clicking on the "Submit claim" icon on the Employee Portal homepage.

- On the forms page, select "I am a Plan Member (Employee)" and choose the relevant state
- Select the necessary form, then select "Complete form online"

Forms can also be submitted via fax or mail by clicking the "Claims forms" icon and downloading the form.

PLEASE NOTE: Microsoft Edge, Google Chrome and/or Firefox are the preferred internet browsers to use when accessing the portal.

We are here for you

If you have questions regarding a claim, please contact our dedicated toll-free number: **(800) 877-5176**

(Monday – Friday, 7:30 a.m. – 5 p.m. CST)

Mutual of Omaha

Employee Assistance Program

Available Services When You Need Help the Most

City of Everman

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap

Basic EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three calls per year (per household) with our in-house Masters level EAP professionals, who will provide the caller with community resources • Additional community resources or possible counseling options come at the expense of the employee
Access	• 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests

Continued on back.

Mutual of Omaha

Basic EAP Services *(continued)*

Features	Value to Company and Employees

Online Services	• An inclusive website with resources and links for additional assistance, including:
	  • Current events and resources
	  • Family and relationships
	  • Emotional well-being
	  • Financial wellness
	  • Substance abuse and addiction
	  • Legal assistance
	  • Physical well-being
	  • Work and career
	• Bilingual article library

Employee Family Legal Services	• Valuable resources available via website
	  • Legal libraries & tools
	  • Legal forms
	• 1 Legal consultation with an attorney per year (up to 30 minutes)
	  • 25% discount for ongoing legal services for same issue

Employee Family Work/Life Services	• Child care resources and referrals • Elder care resources and referrals
Employee Family Financial Services	• Inclusive financial platform powered by Enrich • Personal financial assessment tool • Personalized courses, articles & resource to meet financial needs • Ongoing progress reports on financial health
Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

LIFEWORKS

Employee Assistance Program

LifeWorks

Employee Assistance Program

Core Well-Being Solution

Deliver a total well-being experience that assists employees with best-in-class counselling, content and Work-Life services.

- Emergency Triage
- 24-Hour Crisis Counseling
- Grief Counseling
- Work-Life Services
- Career Counseling
- Family Services
- Emotional Well-being Services
- Work/Professional Services
- Financial Services
- Legal Services
- Education Services
- Management Services
- Critical Incident Stress Management
- On-site Assistance

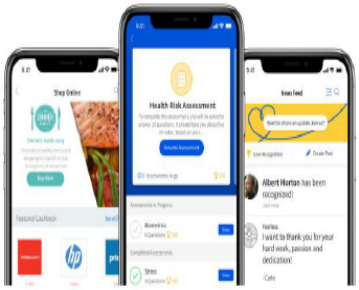
LifeWorks

Mobile Corporate Newsfeed

Technology Platform

Create a social platform in which all participants can interact with personalized well-being content and engage with their company culture.

- Personalized Accounts
- Snackable Well-being Content
- Benefits Updates and News
- Important Corporate Announcements
- Automated Reminders
- Wellness Promotions
- Emergency Communication Channel
- Push Notifications
- Mobile Colleague Directory
- Peer-to-Peer Recognition*



LifeWorks

Perks and Savings Platform

Technology Platform

Improve employees' financial well-being by allowing them not only to save on everyday purchases, but also important life events.

- Employee Benefits Center
- Popular Gift Card Discounts
- Online Cash Back
- In-Store & Online Coupons
- Lifestyle Offers
- Fitness Devices
- Retail & Restaurants Discounts
- Travel & Destination Discounts
- Auto & Home Loans
- Identity Theft Protection
- Exclusive Employer Perks*
- Boosted Cash Back Opportunities*
- Peer-to-Peer Gifting*

Toll Free: 888-456-1324

REQUIRED NOTICES

COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) you and your eligible dependents are entitled to continue your group health benefits coverage (medical, dental, and vision) under your employer's plan after you have left employment with the agency. If you wish to elect COBRA coverage, you have 60 days from the date you receive notice to make an election. You have 45 days after electing coverage to pay the initial premium.

HIPAA Privacy Notice

This notice describes how medical information may be used and disclosed and how you can access this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan – whether received in writing, in an electric medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan.

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plans legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer. You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims, and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask the Human Resource Department to amend the information. For a full copy of the Notice of Privacy Practices describing how protected health information about you may be used and disclosed and how you can get access to the information, contact the Human Resources Department.

Women's Health and Cancer Rights Act of 1998

As Specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction relating to a mastectomy is also entitled to the following benefits:

All stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications of the mastectomy, including lymphedema. Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict for any hospital length of stay relating to childbirth for the mother or newborn child less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, plans and issuers may not. under federal law, require that a provider obtain authorization from the Plan or the Issuer for prescribing a length of stay not more than 48 hours (or 96 hours).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are also eligible for health insurance coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a Special Enrollment opportunity, and you MUST request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling 1-866-444-EBSA (3272).

Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage and your options under Medicare's prescription drug coverage. If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you. Please note that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2016 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered by the medical plan option(s) is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Credible Coverage. Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, if you later enroll within specific time periods.

Availability of Summary Health Care Benefits Information

To help you make an informed choice and verify your benefits, the Summary of Benefits and Coverage (SBC) is available, which summarizes essential information about your health coverage option(s) in a standard format. A copy is available by contacting the Human Resources Department.

Navigate plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Navigate
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☑
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☐
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☑
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☑
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☐
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☐

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Navigate works.

Medical Benefits

	In Network
Annual Medical Deductible	
Individual	$1,000
Family	$2,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit	
Individual	$6,600
Family	$13,200

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

	What You Pay for Services
Copays ($) and Coinsurance (%) for Covered Health Care Services	**Network**
Preventive Care Services	
Preventive Care	
For services provided by your Primary Care Physician, Network obstetrician or gynecologist or for services provided with a referral. *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.*	No copay
Office Services - Sickness & Injury	
Primary Care Physician	
All other covered persons for services provided by your Primary Care Physician, Network obstetrician or gynecologist.	$25 copay
Covered persons less than age 19 for services provided by your Primary Care Physician, Network obstetrician or gynecologist. *Telehealth is covered at the same cost share as in the office.* *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *A deductible does not apply to necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.*	No copay

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Specialist For services provided with a referral. *Telehealth is covered at the same cost share as in the office.* *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *A deductible does not apply to necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.*	$75 copay
Urgent Care *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.*	$100 copay
Virtual Care Services *Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*	No copay
Emergency Care	
Emergency Ambulance	20%*
Non-Emergency Ambulance	20%*
Accidental Dental	20%*
Emergency Room[1] *The Annual Deductible will apply to Emergency Health Care Services provided by an out-of-Network provider in the same manner as services received from Network providers.*	$500 copay
Inpatient Care	
Congenital Heart Disease Surgeries For services provided with a referral.	20%*
Hospital Inpatient Stays For services provided with a referral.	20%*
Inpatient Habilitative Services *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*	The amount you pay is based on where the covered health care service is provided.
Skilled Nursing Facility & Inpatient Rehabilitation Facility Services *Limited to 60 days per year.*	20%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Outpatient Care	
Habilitative Services	
Manipulative treatment services with a referral.	$75 copay
Other habilitative services.	$25 copay
For outpatient therapies (physical therapy, occupational therapy, manipulative treatment, speech therapy, post-cochlear implant aural therapy, cognitive therapy), limits will be the same as, and combined with those stated under Rehabilitation Services. *Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code. Visit limits do not apply if the primary diagnosis is for a Mental Illness.*	
Home Health Care *Limited to 60 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*	20%*
Lab Testing *Limited to 18 Definitive Drug Tests per year.* *Limited to 18 Presumptive Drug Tests per year.*	20%*
Major Diagnostic and Imaging	$500 copay
Physician Fees for Surgical and Medical Services	
For services provided by your Primary Care Physician, Network obstetrician or gynecologist.	20%*
For services provided with a referral.	20%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Rehabilitation Services	
Manipulative treatment services with a referral.	$75 copay
Other rehabilitation services.	$25 copay
Limited to 20 visits of occupational therapy per year.	
Limited to 36 visits of cardiac rehabilitation therapy per year.	
Limited to 20 visits of manipulative treatments per year.	
Limited to 20 visits of cognitive rehabilitation therapy per year.	
Limited to 20 visits of speech therapy per year.	
Limited to 20 visits of pulmonary rehabilitation therapy per year.	
Limited to 20 visits of physical therapy per year.	
Limited to 30 visits of post-cochlear implant aural therapy per year.	
Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code.	
Scopic Procedures	
For services provided by your Primary Care Physician, Network obstetrician or gynecologist.	20%*
For services provided with a referral.	20%*
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	
Surgery	
For services provided by your Primary Care Physician, Network obstetrician or gynecologist.	20%*
For services provided with a referral.	20%*
Therapeutic Treatments	20%*
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	
X-ray and other Diagnostic Testing	20%*
Supplies and Services	
Diabetes Self-Management and Training	The amount you pay is based on where the covered health care service is provided.

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Diabetes Self-Management Items *Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with diabetes.*	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.
Durable Medical Equipment, Orthotics and Supplies *Limited to a single purchase of a type of DME or orthotic every three years.* *Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*	20%*
Enteral Nutrition	20%*
Hearing Aids *Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*	20%*
Ostomy Supplies	20%*
Pharmaceutical Products *This includes medications given at a doctor's office, or in a covered person's home.*	20%*
Prosthetic Devices *Limited to a single purchase of each type of prosthetic device every three years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*	20%*
Urinary Catheters	20%*
Pregnancy	
Maternity Services	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
Mental Health Care & Substance Related and Addictive Disorder Services	
Inpatient *Benefits under this section are provided under the same terms and conditions without quantitative or non-quantitative treatment limitations that are more restrictive as are applicable to medical and surgical treatments.*	20%*
Outpatient *Benefits under this section are provided under the same terms and conditions without quantitative or non-quantitative treatment limitations that are more restrictive as are applicable to medical and surgical treatments.*	$25 copay

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Partial Hospitalization *Benefits under this section are provided under the same terms and conditions without quantitative or non-quantitative treatment limitations that are more restrictive as are applicable to medical and surgical treatments.*	20%*
Other Services	
Acquired Brain Injury - Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	The amount you pay is based on where the covered health care service is provided.
Acquired Brain Injury - Outpatient Post-Acute Care, Transitional Services and Rehabilitation Services	$25 copay
Cellular or Gene Therapy *Cellular or Gene Therapy services must be received from a Network Transplant Provider. You may select a Network Transplant Provider most suitable to treat your condition.*	The amount you pay is based on where the covered health care service is provided.
Clinical Trials	The amount you pay is based on where the covered health care service is provided.
Developmental Delay Services	The amount you pay is based on where the covered health care service is provided.
Fertility Preservation for Iatrogenic Infertility *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.*	20%*
Gender Dysphoria	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.
Hospice Care	20%*
Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings	No copay
Osteoperosis Detection and Prevention	The amount you pay is based on where the covered health care service is provided.
Preimplantation Genetic Testing (PGT) and Related Services *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.* *Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.*	20%*
Reconstructive Procedures	The amount you pay is based on where the covered health care service is provided.

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network
Speech and Hearing Services *The amount you pay is based on where the covered health care service is provided, except that the limit for Rehabilitation Services - Outpatient Therapy and Manipulative Treatment does not apply to speech and hearing services.* *Benefits for the purchase or fitting of hearing aids are not provided under this Covered Health Service category, but are instead provided under the Hearing Aids category in this benefit summary.*	The amount you pay is based on where the covered health care service is provided.
Telehealth and Telemedicine Services	The amount you pay is based on where the covered health care service is provided.
Temporomandibular Joint (TMJ) Services	The amount you pay is based on where the covered health care service is provided.
Transplantation Services *Network Benefits must be received from a Network Transplant Provider. You may slect a Network Transplant Provider most suitable to treat your condition.*	The amount you pay is based on where the covered health care service is provided.

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	Standard Select - Walgreens
Prescription Drug List	Advantage w/ SMCS Drugs

	In Network
Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

Prescription Drug Product Tier Level	Up to a 31-day supply Retail Network	Up to a 90-day supply Mail Order Network Pharmacy**
Tier 1 $	$10	$25
Tier 2 $$	$35	$87.50
Tier 3 $$$	$85	$212.50
Preferred Specialty Prescription Drug Product Tier Level	**Preferred Specialty Retail Network**	**Mail Order Preferred Specialty Network Pharmacy****
Tier 1 $	$10	Not covered***
Tier 2 $$	$150	Not covered***
Tier 3 $$$	$500	Not covered***

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

***Maximum Network Coverage for Specialty Prescription Drug Products dispensed through Designated Pharmacy. See Designated Pharmacies section of your Outpatient Prescription Drug Rider.

Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☐
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☑

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$3,000	$5,000
Family	$6,000	$10,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	$4,000	$10,000
Family	$8,000	$20,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Preventive Care Services		
Preventive Care *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copy, co-insurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.*	No copay	30%*
Office Services - Sickness & Injury		
Primary Care Physician *Telehealth is covered at the same cost share as in the office.* *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *A deductible does not apply to necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.*	No copay*	30%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Specialist *A deductible does not apply to necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.* *Telehealth is covered at the same cost share as in the office.* *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.*	No copay*	30%*
Urgent Care *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.*	No copay*	30%*
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*	No copay*	30%*
Emergency Care		
Emergency Ambulance	No copay*	No copay*
Non-Emergency Ambulance[1]	No copay*	30%*
Accidental Dental	No copay*	No copay*
Emergency Room[1]	No copay*	No copay*
Inpatient Care		
Congenital Heart Disease Surgeries[1]	No copay*	30%*
Hospital Inpatient Stays[1]	No copay*	30%*
Inpatient Habilitative Services[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*	The amount you pay is based on where the covered health care service is provided.	
Skilled Nursing Facility & Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year.*	No copay*	30%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Outpatient Care		
Habilitative Services *For outpatient therapies (physical therapy, occupational therapy, manipulative treatment, speech therapy, post-cochlear implant aural therapy, cognitive therapy), limits will be the same as, and combined with those stated under Rehabilitation Services.* *Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code. Visit limits do not apply if the primary diagnosis is for a Mental Illness.*	No copay*	30%*
Home Health Care[1] *Limited to 60 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*	No copay*	30%*
Lab Testing[1] *Limited to 18 Presumptive Drug Tests per year.* *Limited to 18 Definitive Drug Tests per year.*	No copay*	30%*
Major Diagnostic and Imaging[1]	No copay*	30%*
Physician Fees for Surgical and Medical Services	No copay*	30%*
Rehabilitation Services *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 20 visits of occupational therapy per year.* *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.* *Limited to 20 visits of speech therapy per year.* *Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code.* *Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.*	No copay*	30%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Scopic Procedures *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*	No copay*	30%*
Surgery[1]	No copay*	30%*
Therapeutic Treatments[1] *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*	No copay*	30%*
X-ray and other Diagnostic Testing[1]	No copay*	30%*
Supplies and Services		
Diabetes Self-Management and Training[1]	The amount you pay is based on where the covered health care service is provided.	
Diabetes Self-Management Items[1] *Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with diabetes.*	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	
Durable Medical Equipment, Orthotics and Supplies[1] *Limited to a single purchase of a type of DME or orthotic every three years.* *Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*	No copay*	30%*
Enteral Nutrition	No copay*	30%*
Hearing Aids *Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*	No copay*	30%*
Ostomy Supplies	No copay*	30%*
Pharmaceutical Products *This includes medications given at a doctor's office, or in a covered person's home.*	No copay*	30%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every three years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*	No copay*	30%*
Urinary Catheters	No copay*	30%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Pregnancy		
Maternity Services[1]	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient[1]	No copay*	30%*
Outpatient[1]	No copay*	30%*
Partial Hospitalization[1]	No copay*	30%*
Other Services		
Acquired Brain Injury - Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1]	The amount you pay is based on where the covered health care service is provided.	
Acquired Brain Injury - Outpatient Post-Acute Care, Transitional Services and Rehabilitation Services[1]	No copay*	30%*
Cellular or Gene Therapy[1] *For Network Benefits, Cellular or Gene Therapy services must be received from a Network Transplant Provider. You may select a Network Transplant Provider most suitable to treat your condition.*	The amount you pay is based on where the covered health care service is provided.	
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.	
Developmental Delay Services	The amount you pay is based on where the covered health care service is provided.	
Fertility Preservation for Iatrogenic Infertility[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.*	No copay*	30%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Hospice Care[1]	No copay*	30%*
Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings	No copay	30%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Network	Out-of-Network
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.* *Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.*	No copay*	30%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.	
Speech and Hearing Services *The amount you pay is based on where the covered health care service is provided, except that the limit for Rehabilitation Services - Outpatient Therapy and Manipulative Treatment does not apply to speech and hearing services.* *Benefits for the purchase or fitting of hearing aids are not provided under this Covered Health Service category, but are instead provided under the Hearing Aids category in this benefit summary.*	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services[1]	The amount you pay is based on where the covered health care service is provided.	
Transplantation Services[1] *Network Benefits must be received from a Network Transplant Provider. You may slect a Network Transplant Provider most suitable to treat your condition.*	The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details		
Pharmacy Network	Standard Select - Walgreens	
Prescription Drug List	Advantage w/ SMCS Drugs	
	In Network	**Out of Network**
Annual Pharmacy Deductible		
Individual	See the Annual Medical Deductible section	
Family	See the Annual Medical Deductible section	

The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.

Annual Deductible - Network and Out-of-Network

	Up to a 31-day supply		Up to a 90-day supply
Prescription Drug Product Tier Level	**Retail Network**	**Out-of-Network Pharmacy**	**Mail Order Network Pharmacy****
Tier 1 $	$10*	$10*	$25*
Tier 2 $$	$35*	$35*	$87.50*
Tier 3 $$$	$70*	$70*	$175*
Preferred Specialty Prescription Drug Product Tier Level	**Preferred Specialty Retail Network**	**Preferred Specialty Out-of-Network Pharmacy**	**Mail Order Preferred Specialty Network Pharmacy****
Tier 1 $	$10*	$10*	Not covered***
Tier 2 $$	$150*	$150*	Not covered***
Tier 3 $$$	$500*	$500*	Not covered***

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

***Maximum Network Coverage for Specialty Prescription Drug Products dispensed through Designated Pharmacy. See Designated Pharmacies section of your Outpatient Prescription Drug Rider.

Choice plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☑
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☐
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☐

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice works.

Medical Benefits

	In Network
Annual Medical Deductible	
Individual	$3,000
Family	$6,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit	
Individual	$4,500
Family	$9,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

	What You Pay for Services	
Copays ($) and Coinsurance (%) for Covered Health Care Services	**Designated Network**	**Network**
Preventive Care Services		
Preventive Care *Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.* *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.*		No copay
Office Services - Sickness & Injury		
Primary Care Physician		
All other covered persons	$30 copay	$30 copay
Covered persons less than age 19	No copay	No copay
Telehealth is covered at the same cost share as in the office. *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.* *A deductible does not apply to necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.*		

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.* *A deductible does not apply to necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.* *Telehealth is covered at the same cost share as in the office.*	$30 copay	$60 copay
Urgent Care *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.*		$75 copay
Virtual Care Services *Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*		No copay
Emergency Care		
Emergency Ambulance		No copay*
Non-Emergency Ambulance		No copay*
Accidental Dental		No copay*
Emergency Room[1]		$300 copay
Inpatient Care		
Congenital Heart Disease Surgeries		No copay*
Hospital Inpatient Stays		No copay*
Inpatient Habilitative Services *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*		The amount you pay is based on where the covered health care service is provided.
Skilled Nursing Facility & Inpatient Rehabilitation Facility Services *Limited to 60 days per year.*		No copay*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network
Outpatient Care		
Habilitative Services *For outpatient therapies (physical therapy, occupational therapy, manipulative treatment, speech therapy, post-cochlear implant aural therapy, cognitive therapy), limits will be the same as, and combined with those stated under Rehabilitation Services.* *Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code. Visit limits do not apply if the primary diagnosis is for a Mental Illness.*		$30 copay
Home Health Care *Limited to 60 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*		No copay*
Lab Testing *Limited to 18 Presumptive Drug Tests per year.* *Limited to 18 Definitive Drug Tests per year.*		No copay
Major Diagnostic and Imaging		No copay*
Physician Fees for Surgical and Medical Services		
Primary care visits	No copay*	No copay*
Specialist care visits	No copay*	No copay*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network
Rehabilitation Services *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.* *Limited to 20 visits of speech therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 20 visits of occupational therapy per year.* *Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.* *Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code.*		$30 copay
Scopic Procedures *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*		No copay*
Surgery		No copay*
Therapeutic Treatments *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*		No copay*
X-ray and other Diagnostic Testing		No copay
Supplies and Services		
Diabetes Self-Management and Training		The amount you pay is based on where the covered health care service is provided.
Diabetes Self-Management Items *Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with diabetes.*		The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Designated Network	Network
Durable Medical Equipment, Orthotics and Supplies *Limited to a single purchase of a type of DME or orthotic every three years.* *Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*		No copay*
Enteral Nutrition		No copay*
Hearing Aids *Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*		No copay*
Ostomy Supplies		No copay*
Pharmaceutical Products *This includes medications given at a doctor's office, or in a covered person's home.*		No copay*
Prosthetic Devices *Limited to a single purchase of each type of prosthetic device every three years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*		No copay*
Urinary Catheters		No copay*
Pregnancy		
Maternity Services		The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient		No copay*
Outpatient		$30 copay
Partial Hospitalization		No copay*
Other Services		
Acquired Brain Injury - Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		The amount you pay is based on where the covered health care service is provided.
Acquired Brain Injury - Outpatient Post-Acute Care, Transitional Services and Rehabilitation Services		$30 copay
Cellular or Gene Therapy *Cellular or Gene Therapy services must be received from a Network Transplant Provider. You may select a Network Transplant Provider most suitable to treat your condition.*		The amount you pay is based on where the covered health care service is provided.

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services	
	Designated Network	Network
Clinical Trials		The amount you pay is based on where the covered health care service is provided.
Developmental Delay Services		The amount you pay is based on where the covered health care service is provided.
Fertility Preservation for Iatrogenic Infertility *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.*		No copay*
Gender Dysphoria		The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.
Hospice Care		No copay*
Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings		No copay
Preimplantation Genetic Testing (PGT) and Related Services *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.* *Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.*		No copay*
Reconstructive Procedures		The amount you pay is based on where the covered health care service is provided.
Speech and Hearing Services *The amount you pay is based on where the covered health care service is provided, except that the limit for Rehabilitation Services - Outpatient Therapy and Manipulative Treatment does not apply to speech and hearing services.* *Benefits for the purchase or fitting of hearing aids are not provided under this Covered Health Service category, but are instead provided under the Hearing Aids category in this benefit summary.*		The amount you pay is based on where the covered health care service is provided.
Temporomandibular Joint (TMJ) Services		The amount you pay is based on where the covered health care service is provided.
Transplantation Services *Network Benefits must be received from a Network Transplant Provider. You may slect a Network Transplant Provider most suitable to treat your condition.*		The amount you pay is based on where the covered health care service is provided.

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	Standard Select - Walgreens
Prescription Drug List	Advantage w/ SMCS Drugs

	In Network
Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

Prescription Drug Product Tier Level	Up to a 31-day supply Retail Network	Up to a 90-day supply Mail Order Network Pharmacy**
Tier 1 $	$10	$25
Tier 2 $$	$35	$87.50
Tier 3 $$$	$85	$212.50
Preferred Specialty Prescription Drug Product Tier Level	**Preferred Specialty Retail Network**	**Mail Order Preferred Specialty Network Pharmacy****
Tier 1 $	$10	Not covered***
Tier 2 $$	$150	Not covered***
Tier 3 $$$	$500	Not covered***

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

***Maximum Network Coverage for Specialty Prescription Drug Products dispensed through Designated Pharmacy. See Designated Pharmacies section of your Outpatient Prescription Drug Rider.

Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☐

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$250	$5,000
Family	$500	$10,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	$3,000	$10,000
Family	$6,000	$20,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care		No copay	50%*
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.			
Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.			
Office Services - Sickness & Injury			
Primary Care Physician			
All other covered persons	$20 copay	$20 copay	50%*
Covered persons less than age 19	No copay	No copay	50%*
Telehealth is covered at the same cost share as in the office.			
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.			
A deductible does not apply to necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.			

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.* *A deductible does not apply to necessary diagnostic follow-up care relating to the screening test for hearing loss of a Dependent child.* *Telehealth is covered at the same cost share as in the office.*	$20 copay	$40 copay	50%*
Urgent Care *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.*		$75 copay	50%*
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*		No copay	50%*
Emergency Care			
Emergency Ambulance		20%*	20%*
Non-Emergency Ambulance[1]		20%*	50%*
Accidental Dental		20%*	20%*
Emergency Room[1]		$250 copay then 20%	$250 copay then 20%
Inpatient Care			
Congenital Heart Disease Surgeries[1]		20%*	50%*
Hospital Inpatient Stays[1]		20%*	50%*
Inpatient Habilitative Services[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.*		The amount you pay is based on where the covered health care service is provided.	
Skilled Nursing Facility & Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year.*		20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Outpatient Care			
Habilitative Services *For outpatient therapies (physical therapy, occupational therapy, manipulative treatment, speech therapy, post-cochlear implant aural therapy, cognitive therapy), limits will be the same as, and combined with those stated under Rehabilitation Services.* *Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code. Visit limits do not apply if the primary diagnosis is for a Mental Illness.*		$20 copay	50%*
Home Health Care[1] *Limited to 60 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*		20%*	50%*
Lab Testing[1] *Limited to 18 Presumptive Drug Tests per year.* *Limited to 18 Definitive Drug Tests per year.*		No copay	50%*
Major Diagnostic and Imaging[1]		20%*	50%*
Physician Fees for Surgical and Medical Services			
Primary care visits	20%*	20%*	50%*
Specialist care visits	20%*	20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Rehabilitation Services *Limited to 20 visits of speech therapy per year.* *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 20 visits of occupational therapy per year.* *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.* *Limits for physical, speech and occupational therapy do not apply when provided to a child for the treatment of Autism Spectrum Disorders or when provided in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resource Code.*		$20 copay	50%*
Scopic Procedures *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*		20%*	50%*
Surgery[1]		20%*	50%*
Therapeutic Treatments[1] *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*		20%*	50%*
X-ray and other Diagnostic Testing[1]		No copay	50%*
Supplies and Services			
Diabetes Self-Management and Training[1]		The amount you pay is based on where the covered health care service is provided.	
Diabetes Self-Management Items[1] *Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with diabetes.*		The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Durable Medical Equipment, Orthotics and Supplies[1] *Limited to a single purchase of a type of DME or orthotic every three years.* *Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*		20%*	50%*
Enteral Nutrition		20%*	50%*
Hearing Aids *Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.*		20%*	50%*
Ostomy Supplies		20%*	50%*
Pharmaceutical Products *This includes medications given at a doctor's office, or in a covered person's home.*		20%*	50%*
Prosthetic Devices[1] *Limited to a single purchase of each type of prosthetic device every three years.* *Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase.*		20%*	50%*
Urinary Catheters		20%*	50%*
Pregnancy			
Maternity Services[1]		The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient[1]		20%*	50%*
Outpatient[1]		$20 copay	50%*
Partial Hospitalization[1]		20%*	50%*
Other Services			
Acquired Brain Injury - Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1]		The amount you pay is based on where the covered health care service is provided.	
Acquired Brain Injury - Outpatient Post-Acute Care, Transitional Services and Rehabilitation Services[1]		$20 copay	50%*
Cellular or Gene Therapy[1] *For Network Benefits, Cellular or Gene Therapy services must be received from a Network Transplant Provider. You may select a Network Transplant Provider most suitable to treat your condition.*		The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Clinical Trials[1]		The amount you pay is based on where the covered health care service is provided.	
Developmental Delay Services		The amount you pay is based on where the covered health care service is provided.	
Fertility Preservation for Iatrogenic Infertility[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products per Covered Person.* *This Benefit limit will be the same as, and combined with, those stated under Preimplantation Genetic Testing (PGT) and Related Services. Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per Covered Person during the entire period of time he or she is enrolled for coverage under the Policy.*		20%*	50%*
Gender Dysphoria[1]		The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Hospice Care[1]		20%*	50%*
Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings		No copay	50%*
Preimplantation Genetic Testing (PGT) and Related Services[1] *Benefit limits for related services will be the same as, and combined with, those stated under Fertility Preservation for Iatrogenic Infertility. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under the Outpatient Prescription Drug Rider.* *Benefits for related services are limited to one Assisted Reproductive Technology (ART) procedure during the entire period of time a Covered Person is enrolled under the Policy. This limit does not include the Preimplantation Genetic Testing (PGT) for the specific genetic disorder.*		20%*	50%*
Reconstructive Procedures[1]		The amount you pay is based on where the covered health care service is provided.	
Speech and Hearing Services *The amount you pay is based on where the covered health care service is provided, except that the limit for Rehabilitation Services - Outpatient Therapy and Manipulative Treatment does not apply to speech and hearing services.* *Benefits for the purchase or fitting of hearing aids are not provided under this Covered Health Service category, but are instead provided under the Hearing Aids category in this benefit summary.*		The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) Services[1]		The amount you pay is based on where the covered health care service is provided.	
Transplantation Services[1] *Network Benefits must be received from a Network Transplant Provider. You may slect a Network Transplant Provider most suitable to treat your condition.*		The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details		
Pharmacy Network	Standard Select - Walgreens	
Prescription Drug List	Advantage w/ SMCS Drugs	
	In Network	**Out of Network**
Annual Pharmacy Deductible		
Individual	You do not have to pay a pharmacy deductible	
Family	You do not have to pay a pharmacy deductible	

	Up to a 31-day supply		Up to a 90-day supply
Prescription Drug Product Tier Level	**Retail Network**	**Out-of-Network Pharmacy**	**Mail Order Network Pharmacy****
Tier 1 $	$10	$10	$25
Tier 2 $$	$35	$35	$87.50
Tier 3 $$$	$85	$85	$212.50
Preferred Specialty Prescription Drug Product Tier Level	**Preferred Specialty Retail Network**	**Preferred Specialty Out-of-Network Pharmacy**	**Mail Order Preferred Specialty Network Pharmacy****
Tier 1 $	$10	$10	Not covered***
Tier 2 $$	$150	$150	Not covered***
Tier 3 $$$	$500	$500	Not covered***

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

***Maximum Network Coverage for Specialty Prescription Drug Products dispensed through Designated Pharmacy. See Designated Pharmacies section of your Outpatient Prescription Drug Rider.

Here's an example of how the plan's costs come into play.

1 At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to welcometouhc.com **> Benefits > Find a Doctor or Facility.**
- Choose **Search for a health plan.**
- Choose **Choice Plus** to view providers in the health plan's network.

Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to welcometouhc.com **> Benefits > Pharmacy Benefits.**
- Select **Advantage** to view the medications that are covered under your plan.

Access your plan online.

With myuhc.com®, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.

Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Private-Duty Nursing
- Weight Loss Programs
- Routine Eye Care (Adult/Child)
- Acupuncture
- Bariatric Surgery
- Long-Term Care
- Cosmetic Surgery
- Non-emergency care when traveling outside the U.S.
- Infertility Treatment
- Glasses
- Routine Foot Care
- Dental Care (Adult/Child)

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product. For an out-of-Network Pharmacy, your reimbursement is based on the Out-of-Network Reimbursement Rate, and you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products including Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product.

Certain Preventative Care Medications may be covered at zero costshare. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Experimental or Investigational or Unproven Services and medications. This exclusion will apply to any off-label drug that is excluded from coverage under this Rider as well as any drug that the U.S. Food and Drug Administration (FDA) has determined to be contraindicated for the treatment of the disease or condition. This exclusion will not apply to drugs prescribed to treat a chronic, disabling, or life-threatening disease or condition if the drug meets certain conditions.
- Drugs available over-the-counter. This exclusion does not apply to over-the-counter items for which Benefits are available as described in the Certificate under Diabetes Services in Section 1: Covered Health Care Services.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. This exclusion does not apply to nutritional supplements for the treatment of Autism Spectrum Disorders, as described in your Certificate; amino acid-based elemental formulas as described under Enteral Nutrition in your Certificate; formulas for phenylketonuria (PKU) or other heritable diseases and enteral formulas and other modified food products.
- Prescription Drug Products when prescribed to treat infertility unless required by state law. This exclusion does not apply to Prescription Drug Products prescribed to treat Iatrogenic Infertility and Preimplantation Genetic Testing (PGT) as described in the Certificate.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Care Service.
- Certain Prescription Drug Products for tobacco cessation.
- Certain compounded drugs.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Growth hormone therapy unless required by state law.
- Prescription Drug Products designed to adjust sleep schedules, such as for jet lag or shift work.
- Prescription Drug Products when prescribed as sleep aids.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Diagnostic kits and products.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.

UnitedHealthcare does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you weren't treated fairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator:

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m. You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at:
http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

We provide free services to help you communicate with us such as letters in others languages or large print. You can also ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla español (**Spanish**), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (**Vietnamese**), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (**Tagalog**), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русский (**Russian**). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث العربية (**Arabic**)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج على بطاقة العضوية الخاصة بك.

ATANSYON: Si w pale Kreyòl ayisyen (**Haitian Creole**), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (**French**), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (**Polish**), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (**Portuguese**), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (**Italian**), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (**German**) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (**Hindi**) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (**Hmong**), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ΠΡΟΣΟΧΗ : Αν μιλάτε Ελληνικά **(Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε το δωρεάν αριθμό που θα βρείτε στην κάρτα ταυτότητας μέλους.

PAKDAAR: Nu saritaem ti Ilocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (**Somali**), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

ગુજરાતી **(Gujarati)**: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વવના મૂલ્યે પરાપ્ય છે. મહેરબાની કરી તમારા આઇડી કાડડની સૂચિપર આપેલો સેભ્યે માટેના ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

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