A GUIDE TO YOUR

Benefits

October 1, 2025—September 30, 2026

PICK THE BEST BENEFITS FOR YOU AND YOUR FAMILY.

The City of Bellmead 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 Bellmead 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, 2025. If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to the HR/Finance Department.

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WHO IS ELIGIBLE?

You are eligible to enroll in the City's benefit plans if you are a regular, full-time employee scheduled to work at least 30 or more hours per week. As a regular, full-time employee, you are eligible for benefits on the beginning of the month after your first 30 days of employment.

DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Your legal spouse (as defined by the federal IRS tax code)
- Your dependent child (up to age 26); A child under the age of 26 who is your natural child, stepchild, legally adopted child, or child for whom you have obtained legal guardianship.
- Disabled Children (over age 26; Unmarried children over the age of 26 who are not able to support themselves due to mental disability, physical disability, mental illness, or developmental disability)

ANNUAL OPEN ENROLLMENT

During annual Open Enrollment, you may change insurance elections for coverage. This is the ONLY time throughout the year that you can make changes without a qualifying event.

Open Enrollment begins on September 4, 2025, and runs through September 12, 2025. The benefits you choose during open enrollment will become effective on October 1, 2025.

HOW TO MAKE CHANGES

Unless you or your eligible dependents experience a life-changing qualifying event, you cannot make changes to your elected 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 (i.e., your child reaches the age limit for eligibility)
- Death of a spouse, child, or other qualified dependent
- Change in residence or workplace that changes your or your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, or a change in coverage under another employer-sponsored plan
- Employment Termination
- Change in employment status (i.e., part-time vs. full-time)
- End of the maximum period for COBRA coverage
- Medicare eligibility

SPECIAL ENROLLMENT RULES

If you choose not to enroll yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents at a later date if:

- You or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must enroll within 60 days of the qualified events shown in the "Special Enrollment Rules" above.

If your dependent also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated "for cause" (including failure to pay the required premiums on time).

In addition to the changes described above, you may enroll yourself and your spouse (with or without the new dependent) in the company health plan following marriage or the adoption, placement for adoption, or birth of a child, as long as you request enrollment within 30 days of the event.

You must be enrolled to cover your dependents.

If you have a special enrollment event and want to enroll for health coverage, contact Human Resources.

UnitedHealthcare Medical Insurance

The City of Bellmead will contribute 100% of the Employee Only cost of the UHC EITY POS HSA PLAN. All costs associated with adding spouses and/or dependents will be the responsibility of the employee and deducted via pre-tax payroll deduction.

ALL MEDICAL PLANS OPERATE UNDER A CALENDAR YEAR DEDUCTIBLE (1/01/2026 - 12/31/2026)

The following chart compares our benefits that will take effect October 1st, 2025. To find a doctor in network, please visit www.myuhc.com

	UHC EITY (POS HSA)	UHC EI3G (POS Premier)	UHC EI3F (POS Premier)
Physician Visit Specialist Visit	100% after deductible 100% after deductible	$35 Copay* $70 Copay	$35 Copay* $70 Copay
Member Coinsurance (in|out)	100% | 70%	80% | 50%	80% | 50%
Urgent Care	100% after deductible	$50 Copay	$50 Copay
Deductible - Individual - Family	$3,500 $7,000	$1,500 $3,000	$1,000 $2,000
Hospitalization	100% After deductible	80% After Deductible	80% After Deductible
Preventive Care	Covered 100%	Covered 100%	Covered 100%
Emergency Room	100% after deductible	80% after $500 Copay	80% after $500 Copay
Out-of-Pocket Max - Individual - Family	(Includes Deductible) $3,500 $7,000	(Includes Deductible) $5,000 $10,000	(Includes Deductible) $4,500 $9,000
Prescription Drugs - Tier 1 - Tier 2 - Tier 3	100% after deductible 100% after deductible 100% after deductible	$15 copay $45 copay $85 copay	$15 copay $45 copay $85 copay

*$0 co-pay for children under the age of 19

YOUR MEDICAL COST

EMPLOYEE SEMI-MONTHLY PAYROLL DEDUCTIONS (EFFECTIVE OCTOBER 1, 2025)				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
EITY (POS HSA)	$0.00	$355.68	$203.50	$493.81
EI3G (POS Premier)	$36.87	$445.33	$270.58	$603.96
EI3F (POS Premier)	$39.67	$452.14	$275.67	$612.32

24/7 virtual care. Zero dollars.

Connect to a provider anytime, anywhere with 24/7 Virtual Visits. With your health plan, your cost is usually $0.[1]

Another way to get care

With 24/7 Virtual Visits, providers may treat a wide range of health conditions—many of the same ones treated in an emergency room (ER) or urgent care. If needed, providers may even prescribe medications.[2]

- Cough
- Headache
- Sore Throat
- Fatigue / Weakness
- Nasal discharge
- Difficulty sleeping
- Congestion / sinus
- Fever
- Loss of appetite

Looking for smart savings?

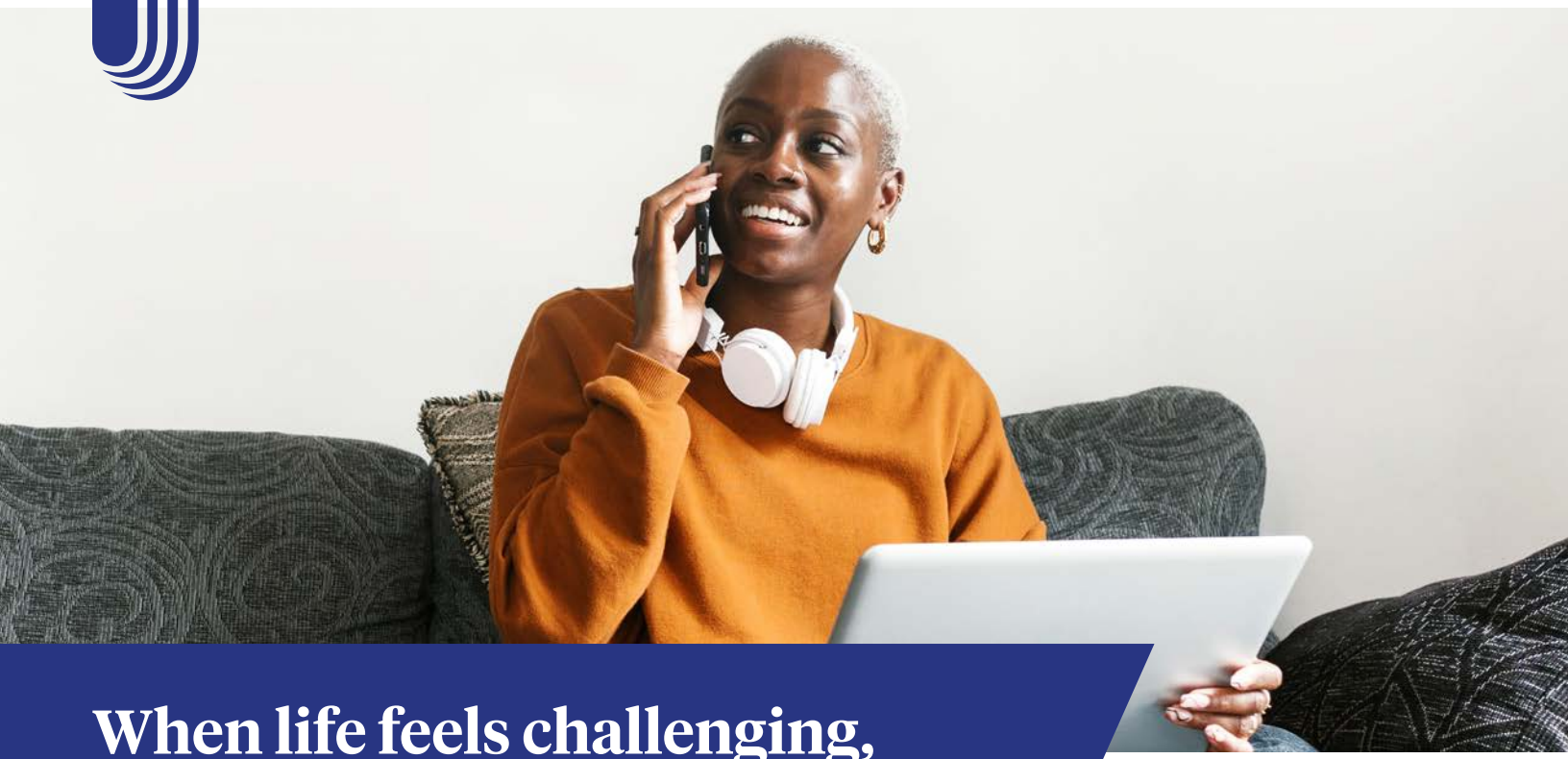
An estimated 25% of ER visits may be treated with a 24/7 Virtual Visit—bringing a potential $2,000[3] cost down to

$0

Visit myuhc.com/virtualvisits | **Call** 1-855-615-8335 | **Open** UnitedHealthcare® app

United Healthcare

continued



When life feels challenging, get caring and confidential help

Your Employee Assistance Program (EAP) offers access to personalized support, resources and no-cost referrals. It's confidential one-on-one help from a master's-level specialist.

No-cost, 24/7 access to support in the moments that matter

EAP helps you and your family with a range of issues, including:

- Identifying resources for managing stress, anxiety and depression
- Offering specialized help in improving relationships at home or work
- Providing guidance on legal and financial concerns
- Finding ways to help you cope with occupational stress and burnout
- Connecting you with care for addressing substance use issues

Call EAP at 1-888-887-4114

- 3 free counseling sessions per incident, per year
- Confidential and private; services will not be shared with your employer

Scan for more info

Use your phone's camera to scan this code and learn more.

United Healthcare

$0 cost for certain medications*

We're making medications that may be essential to your health more affordable.

The new UnitedHealthcare Vital Medication Program offers certain drugs at **no additional cost.*** This means there may be no out-of-pocket costs for preferred insulins and certain other medications, including:

- ✔ **Insulin** – rapid, short and long-acting
- ✔ **Epinephrine** – allergic reactions
- ✔ **Glucagon** – hypoglycemia (low blood sugar)
- ✔ **Naloxone** – opioid overuse
- ✔ **Albuterol** – asthma

To see if you're eligible for no out-of-pocket costs on preferred insulins and other prescription drugs, sign in to myuhc.com/rx

United Healthcare

*Available to eligible members. Check your coverage details at **myuhc.com/rx.**

If you are not currently enrolled with UnitedHealthcare pharmacy benefit coverage, you may access your health plan's member website for additional information during your open enrollment period or you may contact your employer or health plan for additional information.

Medications are categorized by common therapeutic conditions in this reference guide for ease of reference only. These categories do not determine coverage for the medication for your condition. Your benefit plan determines how these medications may be covered for you.

Where differences are noted between this reference guide and your benefit plan documents, the benefit plan documents will govern. This document applies to commercial group members of UnitedHealthcare plans.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Health plan coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Stop-loss insurance is underwritten by All Savers Insurance Company (except CA, MA, MN, NJ and NY), UnitedHealthcare Insurance Company in MA and MN, UnitedHealthcare Life Insurance Company in NJ, UnitedHealthcare Insurance Company of New York in NY, and All Savers Life Insurance Company of California in CA. Optum Rx® is an affiliate of United HealthCare Insurance Company.

Get fit. Get results.

Fitness should be easy, flexible and doable for everyone. Real Appeal® is an online weight management and healthy lifestyle program designed to spark a healthy transformation—at no additional cost to members.

It all starts with simple, realistic goals.

Support to get you moving

Fitness on Demand™

Get moving and motivated with hundreds of on-demand workouts, available anytime, anywhere, at no additional cost.

Online coaching

Set fitness goals and track progress with the help of a coach.

Success kit

Start your health journey with scales, a balanced portion plate and access to online fitness content.

You have access to Real Appeal®, a proven program built to help you succeed through workouts, ongoing support and helpful resources — at no additional cost as an eligible member.

Visit enroll.realappeal.com or scan the QR code to sign up today.

The Real Appeal program is available to eligible members at no additional cost as part of your health benefits.
The Real Appeal program is educational in nature and is not a substitute for medical advice.

Get in on UHC Rewards

Good news—your health plan comes with a way to earn up to $300. UnitedHealthcare Rewards is included in your health plan at no additional cost.

There's so much good to get

With UHC Rewards, a variety of actions—including things you may already be doing, like tracking your steps or sleep—lead to rewards. The activities you go for are up to you, and the same goes for ways to spend your earnings.

Here are just a few of the ways you can earn:

Earn up to
$300

Connect a tracker	**$25**
Take a health survey	**$15**
Get an annual checkup	**$25**
Get a biometric screening	**$50**

Visit UHC Rewards for the full list of rewardable activities that are available to you—and look for new ways of earning rewards to be added throughout the year.

continued

United Healthcare

There are 2 ways to get started

On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards
- Choose reward activities that inspire you—and start earning

Your health

Get in on an experience that's designed to help inspire healthier habits

Your goals

Personalize how you earn by choosing the activities that are right for you

Your rewards

Earn up to $300 for completing rewardable activities

Questions?

Call customer service at **1-866-230-2505**

United Healthcare

HEALTH SAVINGS ACCOUNT (HSA)

If you participate in the high-deductible plan EITY (POS HSA), you can set aside money in a Health Savings Account (HSA) before taxes are deducted to pay for eligible medical, dental and vision expenses. An HSA is similar to a flexible spending account in that you are eligible to pay for health care expenses with pre-tax dollars. There are several advantages of an HSA. For instance, money in an HSA can be invested much like 401(k) funds are invested. Unused money in an HSA account is not forfeited at the end of the year and is carried forward. Also, your HSA account is yours to keep which means that you can take it with you if you change jobs or retire. If you have any money remaining in your HSA after your retirement, you may withdraw the money as cash.

The City of Bellmead contributes $50 to everyone's HSA and then matches up to another $25 if the employee contributes.

The maximum amount that you can contribute to an HSA in 2026 is $4,300 for individual coverage and $8,550 for family coverage. Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000.

Eligibility for the HSA

The main requirement for opening an HSA is having a high-deductible health plan that meets IRS guidelines for the annual deductible and out-of-pocket maximum. To be an eligible individual and qualify for an HSA, you must also meet the following requirements.

- You are not covered by a non-HDHP health plan (such as a spouse's plan) or Medicare
- You have not received Veterans Administration (VA) benefits within the past three months.
- You cannot be claimed as a dependent on another person's tax return.
- You are not covered by a general-purpose health care flexible spending account (FSA) or health reimbursement account (HRA).

Using your HSA

You may use funds in your health savings account to pay for an IRS-qualified medical expense (including dental and vision care). This may include expenses that apply toward your deductible, co-insurance, or even co-pays. Funds in the account can be used for yourself or any qualifying relative as defined by the IRS; the qualifying relative does not have to be enrolled on the high-deductible health plan. For a complete list of IRS-qualified medical expenses, visit irs.gov.

As long as the IRS-qualified medical expenses were incurred after your HSA was established, you can pay them or reimburse yourself with HSA funds at any time. You DO NOT have to submit receipts or show documentation of your expenses to the company to use your HSA. However, it's important that you keep sufficient records in the event you are audited by the IRS.

Should you choose to do so, you can take money out of your HSA for ineligible expenses. However, the IRS will tax these withdrawals and assess a 20% penalty.

UNITEDHEALTHCARE 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 Bellmead is excited to offer a comprehensive dental plan to employees, in which they will contribute 100% of the employee only cost to the plan. All costs associated with adding spouses and/or dependents will be the responsibility of the employee and deducted via pre-tax payroll deduction. The dental plan allows employees to visit a dentist in or out of network. To search for network providers please visit www.myUHC.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, Simple Extractions —80% Coinsurance
Major Services	Root Canal, Crowns, Dentures, Anesthesia/Sedation— 50% Coinsurance
Annual Maximum	$2,000 (Preventative does not accumulate towards Annual Limit)
Adult & Child Ortho	50% up to $2,000 Lifetime Maximum
Out of Network Reimbursement	90th% Usual, Customary & Reasonable Charges
Per Pay Period Payroll Deductions	Employee only—$0.00 Employee & spouse—$14.52 Employee & child(ren)—$22.56 Family—$40.08

EyeMed VISION INSURANCE

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

The City of Bellmead'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 Vision plan offered is 100% Voluntary. Employees will be responsible for 100% of the cost. 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.eyemedvisioncare.com and then click 'find a vision provider'.

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	$150 Allowance once every 24 months from date of service
Contact Lens Allowance	$150 Allowance once every 12 months from date of service
Per Pay Period Payroll Deductions	Employee only—$3.53 Employee & spouse—$6.70 Employee & child(ren)—$7.05 Family—$10.36

City of Bellmead

Insight network

40% OFF

additional complete pair of prescription eyeglasses

20% OFF

non-covered items, including non-prescription sunglasses

Frequency

Exam
once every plan year

Frame
once every other plan year

Lens
once every plan year

Contact Lens
once every plan year

(Plan allows member to receive either contacts and frame, or frames and lens services)

SCHEDULE OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $150 allowance	Up to $75
STANDARD PLASTIC LENSES		
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal/Lenticular	$25 copay	Up to $70
Progressive - Standard	$90 copay	Up to $50
Progressive - Premium Tier 1 - 3	$110 - 135	Up to $50
Progressive - Premium Tier 4	$90 copay, 20% off retail price less $120 allowance	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	$57 - 68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Polycarbonate - Std < 19 years of age	$0 copay	Up to $20
Scratch Coating	$0 copay	Up to $8
Tint	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $75
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	Up to $75
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $300
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

Log into eyemed.com/member to see all plans included with your benefits. EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866-939-3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company® of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-146, form number M-9184. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts

Members already save an average 76% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

[1]Based on weighted average of sample transactions: EyeMed Insight network/$10 exam copay/$10 materials copay/$150 frame or contact lens allowance. 2021 EyeMed Commercial BOB stats.

Create a member account at eyemed.com/member

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

UNITEDHEALTHCARE
BASIC LIFE INSURANCE

Life insurance can help provide for your loved ones if something were to happen to you. The City of Bellmead pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Contact the Human Resources Department if you would like to update your beneficiary information.

Life Coverage	UHC pays
Benefit Amount All Employees	1 x salary up to $200,000 all Guaranteed Issue, with a minimum benefit of $50,000.
Benefit Reduction	The Benefit Amount is reduced to a specified percentage of the *original* Benefit Amount when the covered person reaches a certain age. It is reduced to 35% at age 65 and 15% at age 70.
AD&D Coverage	**UHC pays**
Benefit Amount	1 x salary up to $200,000 all Guaranteed Issue, with a minimum benefit of $50,000
Loss of Life	100% of the Life Benefit Amount
Other Qualified Loss*	25% - 100% of the Life Benefit Amount

*Refer to official plan documents for more specific information about Accidental Death & Dismemberment coverage.

Don’t Forget to Update your Beneficiaries.

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!

UNITEDHEALTHCARE VOLUNTARY LIFE INSURANCE

The City of Bellmead offers all eligible employees the opportunity to elect Life and Accidental Death & Dismemberment (AD&D) coverage for themselves and their eligible dependents. Life coverage ensures that the beneficiary of your choice receives a payment upon the covered member's death. Accidental Death & Dismemberment coverage ensures that the beneficiary of your choice receives a payment should the covered member die or experience some other qualified loss (e.g. loss of a hand, paraplegia, loss of sight) as the result of an accident.

Participation is entirely voluntary, and employees are responsible for paying the full amount of the monthly premium for themselves and their enrolled dependents.

Life Coverage	UHC pays		
	Employee	Spouse	Child
Minimum Benefit Amount	$10,000	$5,000	$10,000
Maximum Benefit Amount	$500,000	$250,000	$10,000
Guarantee Issue*	$100,000	$25,000	$10,000
Benefit Reduction	The Benefit Amount is reduced to a specified percentage of the original Benefit Amount when the covered person reaches a certain age. It is reduced to 35% at age 65 and 15% at age 70.		
Accelerated Benefit	For covered persons who are terminally ill and not expected to live for more than one year, the Accelerated Benefit allows for advanced payment of 80% of the Benefit Amount.		
AD&D Coverage	UHC pays		
Loss of Life	100% of the Life Benefit Amount		
Other Qualified Loss**	25% - 100% of the Life Benefit Amount		

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

*Evidence of Insurability (EOI) may be required for employee and spouse, which is subject to approval by UHC.

Supplemental Life and AD&D

Employee Benefit: **$10,000 to $500,000 in $10,000 increments.**

Spouse Benefit: **$5,000 to $250,000 in $5,000 increments. (not to exceed 100% of the employee benefit)**

Note: Spouse may not have coverage unless the employee has coverage.

The Spouse amount may not exceed the amount for which the employee is eligible.

Guarantee Issue*

Employee	**$100,000, not to exceed 5 times salary**
Spouse	**$25,000**

*Assumes 53% participation

Child Coverage

Birth to 14 days:	**$0**
15 days to 6 months:	**$100**
6 months to age 26:	**$10,000**

Life & AD&D benefits reduce by 35% of the original amount at age 70 and further reduce by 50% of the original amount at age 75.

Employee Supplemental Life/AD&D

Monthly rates per $1,000

Age	Rates
Under 20	$0.076
20-24	$0.076
25-29	$0.086
30-34	$0.107
35-39	$0.117
40-44	$0.128
45-49	$0.179
50-54	$0.262
55-59	$0.471
60-64	$0.709
65-69	$1.343
70+	$2.163

Dependent Life (Children)

Monthly Premium per Family Life/AD&D

$10,000 $2.71

Supplemental Life and AD&D

Premium Cost (Based on 24 payroll deductions per year)

	ATTAINED AGE											
Benefit Amount	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$10,000	$0.38	$0.38	$0.43	$0.54	$0.59	$0.64	$0.90	$1.31	$2.36	$3.55	$6.72	$10.82
$20,000	$0.76	$0.76	$0.86	$1.07	$1.17	$1.28	$1.79	$2.62	$4.71	$7.09	$13.43	$21.63
$30,000	$1.14	$1.14	$1.29	$1.61	$1.76	$1.92	$2.69	$3.93	$7.07	$10.64	$20.15	$32.45
$40,000	$1.52	$1.52	$1.72	$2.14	$2.34	$2.56	$3.58	$5.24	$9.42	$14.18	$26.86	$43.26
$50,000	$1.90	$1.90	$2.15	$2.68	$2.93	$3.20	$4.48	$6.55	$11.76	$17.73	$33.58	$54.08
$60,000	$2.28	$2.28	$2.58	$3.21	$3.51	$3.84	$5.37	$7.86	$14.13	$21.27	$40.29	$64.89
$70,000	$2.66	$2.66	$3.01	$3.75	$4.10	$4.48	$6.27	$9.17	$16.49	$24.82	$47.01	$75.71
$80,000	$3.04	$3.04	$3.44	$4.28	$4.68	$5.12	$7.16	$10.48	$18.84	$28.36	$53.72	$86.52
$90,000	$3.42	$3.42	$3.87	$4.82	$5.27	$5.76	$8.06	$11.79	$21.20	$31.91	$60.44	$97.34
$100,000	$3.80	$3.80	$4.30	$5.35	$5.85	$6.40	$8.95	$13.10	$23.55	$35.45	$67.15	$108.15
$150,000	$5.70	$5.70	$6.45	$8.03	$8.78	$9.60	$13.43	$19.65	$35.33	$53.18	$100.73	$162.23
$200,000	$7.60	$7.60	$8.60	$10.70	$11.70	$12.80	$17.90	$26.20	$47.10	$70.90	$134.30	$216.30
$250,000	$9.50	$9.50	$10.75	$13.38	$14.63	$16.00	$22.38	$32.75	$58.88	$88.63	$167.88	$270.38
$300,000	$11.40	$11.40	$12.90	$16.05	$17.55	$19.20	$26.90	$39.30	$70.65	$106.35	$201.45	$324.45
$350,000	$13.30	$13.30	$15.05	$18.73	$20.48	$22.40	$31.33	$45.85	$82.43	$124.08	$235.03	$378.53
$400,000	$15.20	$15.20	$17.20	$21.40	$23.40	$25.60	$35.80	$52.40	$94.20	$141.80	$268.60	$432.60
$450,000	$17.10	$17.10	$19.35	$24.08	$26.33	$28.80	$40.28	$58.95	$105.98	$159.53	$302.18	$486.68
$500,000	$19.00	$19.00	$21.50	$26.80	$29.25	$32.00	$44.75	$65.50	$117.75	$177.25	$335.75	$540.75

Supplemental Life and AD&D

Employee Benefit: **$10,000 to $500,000 in $10,000 increments.**

Spouse Benefit: **$5,000 to $250,000 in $5,000 increments.**
(not to exceed 100% of the employee benefit)

Note: Spouse may not have coverage unless the employee has coverage.

The Spouse amount may not exceed the amount for which the employee is eligible.

Guarantee Issue*

Employee	**$100,000, not to exceed 5 times salary**
Spouse	**$25,000**

*Assumes 53% participation

Child Coverage

Birth to 14 days:	**$0**
15 days to 6 months:	**$100**
6 months to age 26:	**$10,000**

Life & AD&D benefits reduce by 35% of the original amount at age 70 and further reduce by 50% of the original amount at age 75.

Spouse Supplemental Life/AD&D
Monthly rates per $1,000

Age	Rates
Under 20	$0.076
20-24	$0.076
25-29	$0.086
30-34	$0.107
35-39	$0.117
40-44	$0.128
45-49	$0.179
50-54	$0.262
55-59	$0.471
60-64	$0.709
65-69	$1.343
70+	$2.163

Dependent Life (Children)
Monthly Premium per Family Life/AD&D

$10,000	$2.71

Supplemental Life and AD&D

Premium Cost (Based on 24 payroll deductions per year)

	ATTAINED AGE											
Benefit Amount	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$5,000	$0.19	$0.19	$0.22	$0.27	$0.30	$0.32	$0.45	$0.66	$1.18	$1.77	$3.36	$5.41
$10,000	$0.38	$0.38	$0.43	$0.54	$0.59	$0.64	$0.90	$1.31	$2.36	$3.55	$6.72	$10.82
$15,000	$0.57	$0.57	$0.65	$0.81	$0.88	$0.96	$1.34	$1.97	$3.53	$5.32	$10.07	$16.22
$20,000	$0.76	$0.76	$0.86	$1.07	$1.17	$1.28	$1.79	$2.62	$4.71	$7.09	$13.43	$21.63
$25,000	$0.95	$0.95	$1.08	$1.34	$1.46	$1.60	$2.24	$3.28	$5.89	$8.86	$16.79	$27.04
$30,000	$1.14	$1.14	$1.29	$1.61	$1.76	$1.92	$2.69	$3.93	$7.07	$10.64	$20.15	$32.45
$35,000	$1.33	$1.33	$1.51	$1.88	$2.05	$2.24	$3.13	$4.59	$8.24	$12.41	$23.50	$37.85
$40,000	$1.52	$1.52	$1.72	$2.14	$2.34	$2.56	$3.58	$5.24	$9.42	$14.18	$26.86	$43.26
$45,000	$1.71	$1.71	$1.94	$2.41	$2.63	$2.88	$4.03	$5.90	$10.60	$15.95	$30.22	$48.67
$50,000	$1.90	$1.90	$2.15	$2.68	$2.93	$3.20	$4.48	$6.55	$11.78	$17.73	$33.58	$54.08
$75,000	$2.85	$2.85	$3.23	$4.02	$4.39	$4.80	$6.71	$9.83	$17.66	$26.59	$50.36	$81.11
$100,000	$3.80	$3.80	$4.30	$5.35	$5.85	$6.40	$8.95	$13.10	$23.55	$35.45	$67.15	$108.15
$125,000	$4.75	$4.75	$5.38	$6.69	$7.32	$8.00	$11.19	$16.38	$29.44	$44.31	$83.94	$135.19
$150,000	$5.70	$5.70	$6.45	$8.03	$8.78	$9.60	$13.43	$19.65	$35.33	$53.18	$100.73	$162.23
$175,000	$6.65	$6.65	$7.53	$9.37	$10.24	$11.20	$15.66	$22.93	$41.21	$62.04	$117.51	$189.26
$200,000	$7.60	$7.60	$8.60	$10.70	$11.70	$12.80	$17.90	$26.20	$47.10	$70.90	$134.30	$216.30
$225,000	$8.55	$8.55	$9.68	$12.04	$13.16	$14.40	$20.14	$29.48	$52.99	$79.76	$151.09	$243.34
$250,000	$9.50	$9.50	$10.75	$13.38	$14.63	$16.00	$22.38	$32.75	$58.88	$88.63	$167.88	$270.38

UNITEDHEALTHCARE SHORT TERM DISABILITY

The City of Bellmead offers all eligible employees the option to enroll in Short Term Disability coverage at cost to the employee. STD insurance provides you with a weekly income if you are deemed disabled, in which coverage continues as long as you are certified disabled up to 11 weeks.

Benefit Schedule

Benefit Percentage	60% of Weekly Earnings* to a maximum weekly benefit of $1,000
Elimination Period - Injury	14 Days
Elimination Period - Sickness	14 Days
Benefits Begin – Injury	15th Day
Benefits Begin – Sickness	15th Day
Maximum Period Payable	11 weeks Until LTD begins, whichever is earlier
Pre-Existing Conditions Limitation	3/6
Work Incentive Benefit, Worksite Modification Benefit, Continuity of Coverage	Included

Monthly Rate per $10 of Weekly Benefit	
Age	Rate
Under 20	$0.350
20-24	$0.350
25-29	$0.350
30-34	$0.300
35-39	$0.280
40-44	$0.270
45-49	$0.260
50-54	$0.310
55-59	$0.360
60-64	$0.410
65-69	$0.500
70+	$0.500

**Weekly Earnings means your weekly rate of earnings from your employer in effect immediately prior to the date disability begins. It includes total income before taxes, including deduction made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include bonuses, overtime pay, any other extra compensation or commissions.*

Sample Premium Calculation

(Sample assumes a 30-year-old employee with $45,000 in annual earnings)

Annual Salary ÷ 52	=	Weekly Earnings	x	STD Benefit %	=	÷ 10 (max. $100)	x	STD Rate (from table above)	=	Monthly Premium	x 12 ÷ 24 =	Semi-monthly Premium
$45,000 ÷ 52	=	$865	x	$0.60	=	$51.90	x	$0.327	=	$16.97	x 12 ÷ 24 =	$8.49

Your Premium Calculation

(Enter your salary and the rate for your current age from the table above)

Annual Salary ÷ 52	=	Weekly Earnings	x	STD Benefit %	=	÷ 10 (max. $100)	x	STD Rate (from table above)	=	Monthly Premium	x 12 ÷ 24 =	Semi-monthly Premium
$ ÷ 52	=	$	x	$0.60	=	$	x	$	=	$	x 12 ÷ 24 =	$

UNITEDHEALTHCARE LONG TERM DISABITLITY

The City of Bellmead offers all eligible employees Long Term Disability (LTD) coverage at no cost to the employee. LTD insurance provides you with a monthly income if you are deemed disabled, in which coverage continues as long as you are certified disabled up to social security retirement age, after 90 days.

Benefit Information	
Monthly Benefit Amount	60% of monthly earnings up to $7,500 maximum per month
Maximum Payment Period	To age 65, standard Social Security Retirement Age
Benefit Payments begin on	Day 90
Pre-existing Condition Exclusion	Pre-existing disabilities are *not* covered for the first 12 months that follow the coverage effective date. A pre-existing disability is one that results from an injury or sickness that occurred during the 3 months *prior* to the coverage effective date. Disabilities that arise *during* the first 12 months of coverage will also not be covered during this period.
Rehabilitation Benefit	UnitedHealthcare provides disabled members with rehabilitation benefits to assist with recovery and return to work.
Survivor Benefit	If a disabled member dies, UHC will provide a surviving dependent with a Survivor Benefit payment for 3 months following the member's death.

masa Access

Stay prepared with MASA® Access℠

Comprehensive coverage and care for emergency transport.

Our Emergent Plus membership plan includes:

Emergency Ground Ambulance Coverage[1]
Your out-of-pocket expenses for your emergency ground transportation to a medical facility are covered with MASA.

Emergency Air Ambulance Coverage[1]
Your out-of-pocket expenses for your emergency air transportation to a medical facility are covered with MASA.

Hospital to Hospital Ambulance Coverage[1]
When specialized care is required but not available at the initial emergency facility, your out-of-pocket expenses for the ground or air ambulance transfer to the nearest appropriate medical facility are covered with MASA.

Repatriation Near Home Coverage[1]
Should you need continued care and your care provider has approved moving you to a hospital nearer to your home, MASA coordinates and covers the expense for ambulance transportation to the approved medical facility.

Single Coverage = $8 / month

Family Coverage = $17 / month

Coverage territories
1: United States and Canada.

Disclaimers
This material is for informational purposes only and does not provide any coverage. The benefits listed, and the descriptions thereof, do not guarantee coverage and do not represent the full terms and conditions applicable for usage and may only be offered in some memberships or policies. Premiums, benefits, and coverage vary depending on the plan selected. For a complete list of benefits, premiums, terms, conditions, and restrictions, please refer to the applicable member services agreement or policy for your state. For additional information and disclosures about MASA plans, visit: https://info.masamts.com/masa-mts-disclaimers

Did you know?

51.3 million

emergency responses occur each year

MASA protects families against uncovered costs for emergency transportation and provides connections with care services.

Source: NEMSIS, National EMS Data Report, 2023

About MASA

MASA is coverage and care you can count on to protect you from the unexpected. With us, there is no “out-of-network” ambulance. Just send us the bill when it arrives and we’ll work to ensure charges are covered. Plus, we’ll be there for you beyond your initial ride, with expert coordination services on call to manage complex transport needs during or after your emergency — such as transferring you and your loved ones home safely.

Protect yourself, your family, and your family’s financial future with MASA.

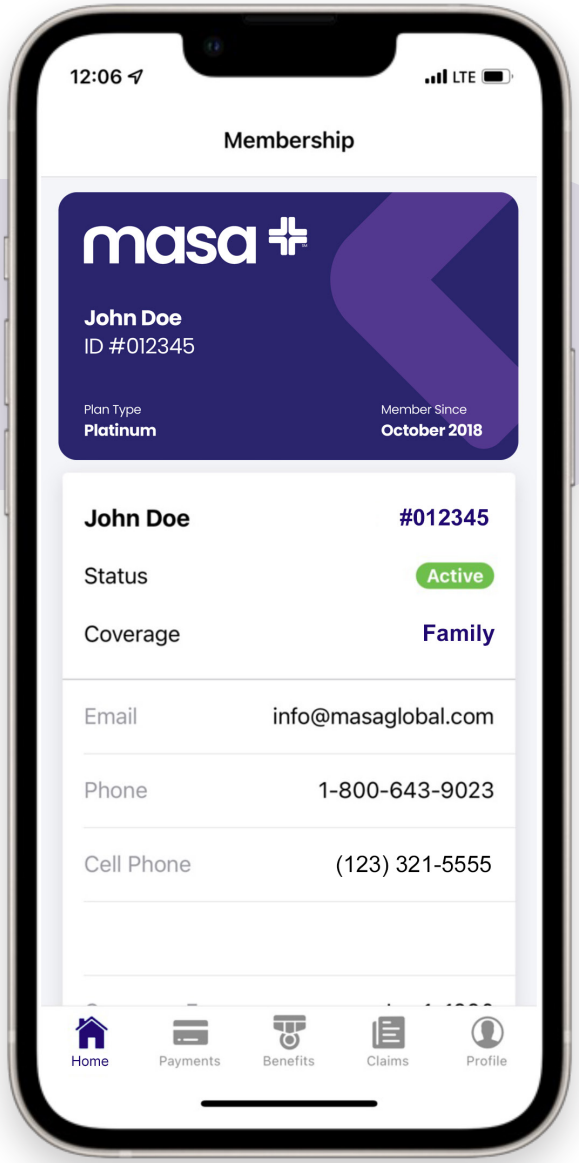
masa

Offering	Product	Type	Voluntary Price	Total Invoice
Voluntary	Emergent Plus	Single	$8.00	$8.00
Voluntary	Emergent Plus	Family	$17.00	$17.00

Download the MASA mobile app today!

Registration is easy with your member ID.

- Access your digital ID cards.
- View plan documents and benefits.
- View your claims history.



You now have access to emergency transportation solutions in the palm of your hand. The MASA App allows you to check and update your membership information, view payment history, immediately access benefits and to view up-to-the minute claims processing information, along with many more exciting features to come.

This one stop shop is a must have app for all MASA Global members, while at home or traveling.

Download on the App Store

GET IT ON Google Play

masa Access

How to use your MASA benefits

Transportation coordination services

Access transport services for the following benefits:

- Repatriation Near Home Coverage
- Child, Pet, and Vehicle Return Coverages
- Companion Transportation Coverage
- Hospital Visitor Transportation Coverage
- Patient Return Transportation Coverage
- Sick While Away from Home Expense Protection
- Organ Retrieval & Organ Recipient Transport Coverage
- Mortal Remains Transportation Coverage

When to access:
During or immediately following your emergency care treatment.

How to access:
Call 800-643-9023.
The MASA Transport Team is available 24/7/365 to assist you and will begin making the necessary arrangements, including working with your medical team.
Note: *If you are traveling out of the U.S., please submit your dates of travel through the member portal or to travel@masaglobal.com.*

View your benefits online at: masaaccess.com/member or through the MASA app.

Claims

Benefits that you submit claims for include:

- Emergency Ground Ambulance Coverage
- Emergency Air Ambulance Coverage
- Hospital to Hospital Ambulance Coverage
- Post-Admission Continued Care Transportation Coverage

When to file your claim:
When you receive the ambulance bill.
Note: *Be sure to file within 180 days of the transport.*

$20,000 Max Per Claim – Ground/Air Services

How to file your claim:
Online: masaaccess.com/member
Email: ambulanceclaims@masaglobal.com
Fax: (877) 681-2399

Mail: MASA Global / ATTN: Claims
1250 S. Pine Island Road, Suite 500
Plantation, FL 33324
Include your member number

Note: *To process your claim, in addition to the invoice we may require your health insurance claim form (HICFA) and explanation of benefits (EOB), the ambulance run notes, and the ambulance provider's W9. MASA claim specialists will advise you on how to obtain these.*

Check the status of your claim at: masaaccess.com/member, through the MASA app, or call (800) 643-9023.

MASA connections

Member services: (800) 643-9023

Member site: masaaccess.com/member

Download on the App Store GET IT ON Google Play

MASA app

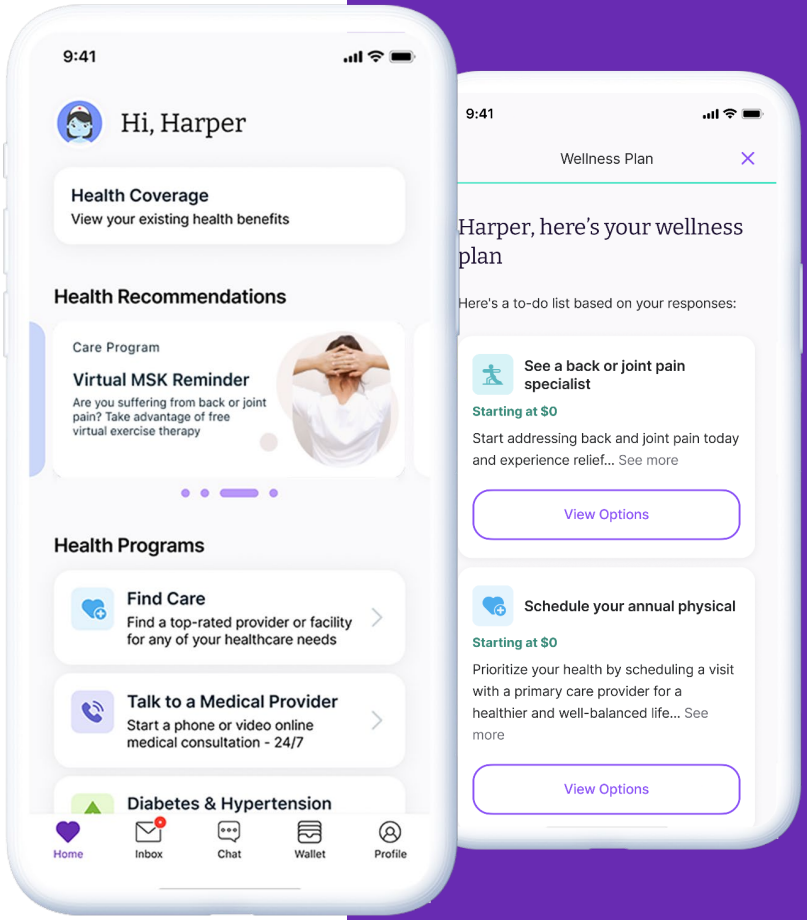
HealthJoy

Welcome to HealthJoy!

ENROLL TODAY!

This cost savings benefit is provided by the City for employees and their dependents.

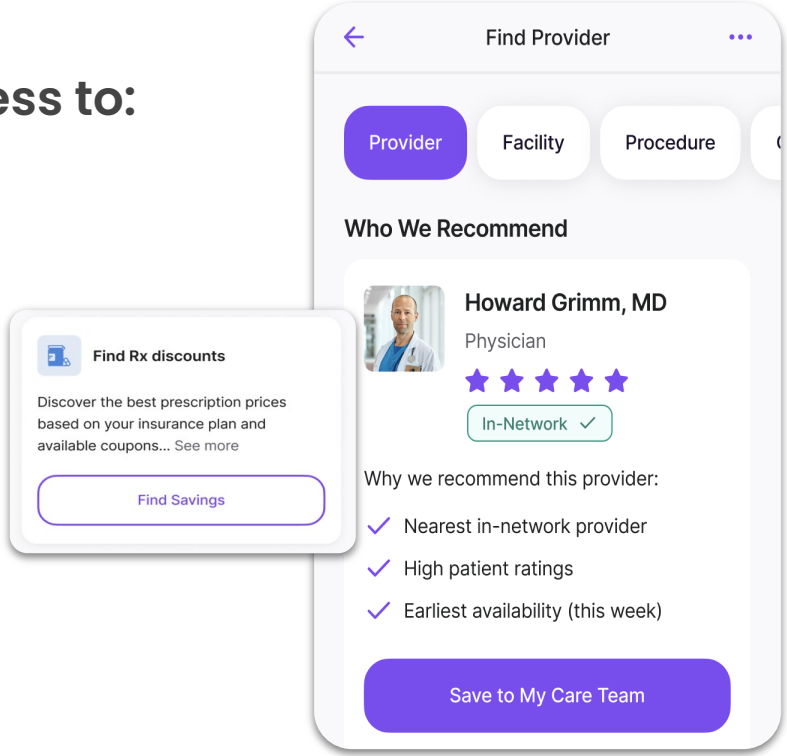
(Note: Enrollment in the medical plan is <u>not</u> required to utilize this benefit.)



How Can HealthJoy Help You?

Activate HealthJoy for instant access to:

- Benefits Wallet
- Healthcare Concierge
- Rx Savings Review
- Appointment Booking
- Provider Recommendations
- HSA/FSA Support



HealthJoy

BENEFIT CONTACT INFORMATION

Benefit	Carrier	Contact Information
Medical and Pharmacy	UnitedHealthcare	(866) 801-4409 myuhc.com – Member Services Call the number on the back of ID Card for Claims / Customer Service
Dental	UnitedHealthcare	(866) 801-4409 myuhc.com – Member Services Call the number on the back of ID Card for Claims / Customer Service
Vision	EYEMED Vision Network	(866) 939-3633 Customercarecenter@eyemed.com
Group Life and AD&D	UnitedHealthcare	(866) 801-4409 – Member Services myuhc.com
MASA – Ambulance Benefit	MASA Ambulatory Services	(800) 643-9023 – 24/7/365 Member Services Ambulanceclaims@masaglobal.com – To File a Claim
HealthJoy – Telemedicine	HealthJoy	(877) 500-3212 – Member Services
AFLAC Representative	AFLAC	Karlo Jones (254) 875-4939 Karlo_Jones@us.aflac.com

HUB

Group Benefits Broker: Rodney Dryden
Account Manager: Peter Mayfield
(940) 294-0316
Peter.mayfield@hubinternational.com

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.

UnitedHealthcare **Insurance Choice Plus EITY / MM**

Coverage For: Family | Plan Type: PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-633-2446 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$3,500** Individual / **$7,000** Family Out-of-Network: **$5,000** Individual / **$10,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$3,500** Individual / **$7,000** Family Out-of-Network: **$10,000** Individual / **$20,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	30% coinsurance	Virtual Visits - 0% coinsurance by a Designated Virtual Network Provider. Office Visit cost share applies to any other Telehealth service based on provider type.
	Specialist visit	0% coinsurance	30% coinsurance	None
	Preventive care/ screening/ immunization	No Charge	\30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *Deductible/coinsurance may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 - Your Lowest Cost Option	Retail: $0 copay Mail-Order: $0 copay	Retail: $0 copay	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Prescription drug costs are subject to the annual deductible. Network deductible will be applied to the out-of-network provider and applies to the Network out-of-pocket limit.
	Tier 2 - Your Mid-Range Cost Option	Retail: $0 copay Mail-Order: $0 copay	Retail: $0 copay	
	Tier 3 - Your Mid-Range Cost Option	Retail: $0 copay Mail-Order: $0 copay	Retail: $0 copay	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	0% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	0% coinsurance	*0% coinsurance	*Network deductible applies.
	Emergency medical transportation	0% coinsurance	*0% coinsurance	*Network deductible applies.
	Urgent Care	0% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	0% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	30% coinsurance	Network All Other: 0% coinsurance. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	0% coinsurance	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	30% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount or $500, whichever is less.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Rehabilitation services	0% coinsurance	30% coinsurance	Limits per calendar year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits.
	Habilitative services	0% coinsurance	30% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of autism or early childhood intervention.
	Skilled nursing care	0% coinsurance	30% coinsurance	Limited to 60 days per calendar year, combined with inpatient rehabilitation. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Durable medical equipment	0% coinsurance	30% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Hospice services	0% coinsurance	30% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount or $500, whichever is less.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental Care
- Glasses
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine Eye Care
- Routine foot care - Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic (manipulative) care - 20 visits per calendar year
- Hearing aids

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Texas Department of Insurance at 1-800-252-3439 or tdi.texas.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-633-2446.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,560

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,700

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,500
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.

UnitedHealthcare Insurance Choice Plus EI3G / Z9

Coverage For: Family | Plan Type: PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-633-2446 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,500** Individual / **$3,000** Family Out-of-Network: **$5,000** Individual / **$10,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$5,500** Individual / **$11,000** Family Out-of-Network: **$10,000** Individual / **$20,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay per visit, deductible does not apply	50% coinsurance	Under age 19 - Network visits are covered at No Charge. Virtual Visits - No Charge by a Designated Virtual Network Provider. Office Visit cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Designated Network: $35 copay per visit, deductible does not apply Network: $70 copay per visit, deductible does not apply	50% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/ screening/ immunization	No Charge	\50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *Deductible/coinsurance may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 - Your Lowest Cost Option	Retail: $15 copay, deductible does not apply. Mail-Order: $37.50 copay, deductible does not apply. Specialty Retail: $15 copay, deductible does not apply.	Retail: $15 copay, deductible does not apply. Specialty Retail: $15 copay, deductible does not apply.	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy. Specialty drugs are not covered through mail order. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 - Your Mid-Range Cost Option	Retail: $45 copay, deductible does not apply. Mail-Order: $112.50 copay, deductible does not apply. Specialty Retail: $100 copay, deductible does not apply.	Retail: $45 copay, deductible does not apply. Specialty Retail: $100 copay, deductible does not apply.	
	Tier 3 - Your Mid-Range Cost Option	Retail: $85 copay, deductible does not apply. Mail-Order: $212.50 copay, deductible does not apply. Specialty Retail: $300 copay, deductible does not apply.	Retail: $85 copay, deductible does not apply. Specialty Retail: $300 copay, deductible does not apply.	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$500 copay per visit then 20% coinsurance, deductible does not apply	$500 copay per visit then 20% coinsurance, deductible does not apply	None
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Urgent Care	$50 copay per visit, deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay per visit, deductible does not apply	50% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance. Intensive Behavior Therapy (ABA), TMS, ECT, MAT and Psych Testing: 10% coinsurance, deductible does not apply. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount or $500, whichever is less.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Rehabilitation services	$35 copay per visit, deductible does not apply	50% coinsurance	Limits per calendar year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits.
	Habilitative services	$35 copay per visit, deductible does not apply	50% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of autism or early childhood intervention.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year, combined with inpatient rehabilitation. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Durable medical equipment	20% coinsurance	50% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount or $500, whichever is less.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental Care
- Glasses
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine Eye Care
- Routine foot care - Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic (manipulative) care - 20 visits per calendar year
- Hearing aids

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Does this plan provide Minimum Essential Coverage? **Yes**

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Does this plan meet the Minimum Value Standards? **Yes**

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Language Access Services:

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Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-633-2446.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,500**
- **Specialist copay** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	**$1,500**
Copayments	**$10**
Coinsurance	**$1,700**
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$3,270**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,500**
- **Specialist copay** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	**$200**
Copayments	**$500**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Joe would pay is	**$700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,500**
- **Specialist copay** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	**$1,200**
Copayments	**$700**
Coinsurance	**$200**
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,100**

The plan would be responsible for the other costs of these EXAMPLE covered services.

UnitedHealthcare **Insurance Choice Plus EI3F / Z9**

Coverage For: Family | Plan Type: PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-633-2446 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,000** Individual / **$2,000** Family Out-of-Network: **$5,000** Individual / **$10,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$4,500** Individual / **$9,000** Family Out-of-Network: **$10,000** Individual / **$20,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay per visit, deductible does not apply	50% coinsurance	Under age 19 - Network visits are covered at No Charge. Virtual Visits - No Charge by a Designated Virtual Network Provider. Office Visit cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Designated Network: $35 copay per visit, deductible does not apply Network: $70 copay per visit, deductible does not apply	50% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/ screening/ immunization	No Charge	\50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *Deductible/coinsurance may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 - Your Lowest Cost Option	Retail: $15 copay, deductible does not apply. Mail-Order: $37.50 copay, deductible does not apply. Specialty Retail: $15 copay, deductible does not apply.	Retail: $15 copay, deductible does not apply. Specialty Retail: $15 copay, deductible does not apply.	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy. Specialty drugs are not covered through mail order. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 - Your Mid-Range Cost Option	Retail: $45 copay, deductible does not apply. Mail-Order: $112.50 copay, deductible does not apply. Specialty Retail: $100 copay, deductible does not apply.	Retail: $45 copay, deductible does not apply. Specialty Retail: $100 copay, deductible does not apply.	
	Tier 3 - Your Mid-Range Cost Option	Retail: $85 copay, deductible does not apply. Mail-Order: $212.50 copay, deductible does not apply. Specialty Retail: $300 copay, deductible does not apply.	Retail: $85 copay, deductible does not apply. Specialty Retail: $300 copay, deductible does not apply.	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$500 copay per visit then 20% coinsurance, deductible does not apply	$500 copay per visit then 20% coinsurance, deductible does not apply	None
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies.
	Urgent Care	$50 copay per visit, deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay per visit, deductible does not apply	50% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance. Intensive Behavior Therapy (ABA), TMS, ECT, MAT and Psych Testing: 10% coinsurance, deductible does not apply. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	50% coinsurance	Cost sharing does not apply for preventive services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount or $500, whichever is less.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Rehabilitation services	$35 copay per visit, deductible does not apply	50% coinsurance	Limits per calendar year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits.
	Habilitative services	$35 copay per visit, deductible does not apply	50% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of autism or early childhood intervention.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year, combined with inpatient rehabilitation. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Durable medical equipment	20% coinsurance	50% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount or $500, whichever is less.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental Care
- Glasses
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine Eye Care
- Routine foot care - Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic (manipulative) care - 20 visits per calendar year
- Hearing aids

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Texas Department of Insurance at 1-800-252-3439 or tdi.texas.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-633-2446 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-633-2446.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-633-2446.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-633-2446.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,000**
- **Specialist copay** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	**$1,000**
Copayments	**$10**
Coinsurance	**$1,800**
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$2,870**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,000**
- **Specialist copay** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	**$200**
Copayments	**$500**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Joe would pay is	**$700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,000**
- **Specialist copay** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	**$1,000**
Copayments	**$700**
Coinsurance	**$200**
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.