2019 St. Louis Public Schools Benefits Reference Guide

SAINT LOUIS PUBLIC SCHOOLS

Welcome to the St. Louis Public Schools annual enrollment period for Calendar Year 2019. Annual enrollment will begin on **Sunday, November 18, 2018** and end at Midnight, CST on **Saturday, December 1, 2018**. You will be able to make corrections from **Sunday, December 9, 2018** through **Saturday, December 15, 2018**, Midnight, CST. Please use this 2019 enrollment guide, along with your enrollment worksheet, to make changes to medical, dental, vision, supplemental life insurance, and flexible spending accounts benefit options.

We encourage you to review the Enrollment Guide and your personal worksheet to determine your selections for 2019. If you do not make an election, a default enrollment will be made for you as described below.

What's New for 2019?

- **The District has moved to a NEW triple option offer for Medical benefits.**
- The new base plan is covered at 100% by SLPS. The new base plan has a higher deductible with a slight increase to your Out-of-Pocket Maximum.
- There are some rate increases for Medical (which includes Pharmacy).
- Employees who do not make a selection during Annual Enrollment will default to the new Base plan.
- **If you are currently in the Buy-Up plan and want to keep the Buy-Up plan for 2019, you must make a selection during Annual Enrollment.**
- Virtual Visits are now covered at NO Copay for in-network providers in all Medical plans.

What you need to do

- Read the enclosed materials carefully to get answers to your questions.
- Discuss your options with your family. Make sure that you include any individuals who will be affected by your elections in the decision making process.
- **Enroll by the deadline, which is Midnight, CST December 1, 2018**. If you decide to change plans or delete/add eligible dependents, refer to the instructions in the Enrollment Guide. All eligible employees should enroll online at https://portal.adp.com. If you have questions or do not have access to a computer, call the Benefits Call Center at 1-866-345-SLPS (7577). Customer Care Representatives will be available to help you throughout the enrollment period and on an ongoing basis after the enrollment deadline.
- Finally, you will receive a personalized confirmation statement by the week of December 2nd. If your confirmation does not reflect your elections for 2019, call the Benefits Call Center. You will not be allowed to make corrections after December 15, 2018, Midnight, CST.

What you need to remember

- Deductions for dependent coverage are taken from 24 paychecks for 12-month employees and 20 paychecks for non-12-month employees.
- Employee Assistance Services will be provided by Optum.
- Be sure to review your first paycheck in January 2019, to ensure that the correct amount has been deducted.
- Your medical and pharmacy information is combined on one card.
- **If you are participating in Flexible Spending Accounts, you must indicate the amount annually.**
- All employees are required to have Beneficiary Designations in place for their Life Insurance coverage.
- You may select any combination of medical, dental, and/or vision plans, as well as any combination of coverage categories. The choice is up to you!
- Employees who are married to an employee of the St. Louis Public Schools **cannot** cover their spouse on any medical, dental, vision or life plan. (Dual coverage is not allowed.)

Do not forget to make your benefit choices no later than Midnight, CST Saturday, December 1, 2018.

If you do not enroll

If you do not enroll by **December 1**, **2018**, you will not be able to make changes to your benefits until the correction period or next open enrollment period - unless you have a change in status or experience another qualified event under which election changes are allowed. You will default to the coverages listed below.

Default Coverage for 2019

BENEFIT	COVERAGE LEVEL	PLAN
Medical and Prescription Drug Plan	Default Medical Plan unless Buy-Up election	
Dental Plan	Same as in 2018	Same as 2018
Vision Plan	Same as in 2018	Same as 2018
Basic Life Insurance	Same as in 2018	Same as 2018
Supplemental Life Insurance	Same as in 2018	Same as 2018
Healthcare Reimbursement Account	No Coverage	No Coverage
Dependent Care Reimbursement Account	No Coverage	No Coverage

Keep this guide for future reference.

St. Louis Public Schools

Important Dates to Remember

Your Open Enrollment Dates Are:
November 18, 2018 through December 1, 2018

Your Correction Dates are:
December 9, 2018 through December 15, 2018

Your period of coverage dates are:
January 1, 2019 through December 31, 2019

Welcome

The Board of Education of the City of St. Louis is committed to providing employees an affordable, high-quality employee benefits program while managing healthcare and vendor costs effectively.

It's time to enroll for your 2019 health and welfare benefits. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Annual enrollment is the one time during the year when you can make changes to your benefits (other than when you have a qualified family status change such as marriage, death, birth or adoption of a child, etc.). Don't miss this opportunity to review your benefit needs and the needs of your family. Review your current coverage; think about whether your needs have changed since you made those benefit decisions.

- Open enrollment will take place from Sunday, November 18, through Saturday, December 1, 2018 at Midnight, CST.
- Review this guide and your personal enrollment worksheet before you enroll for your benefits. If you have any questions, you may contact the Benefits Call Center phone line at 1-866-345-SLPS (7577) for more information.
- If you are enrolling online - the enrollment website will be available **24 hours a day throughout the enrollment period. To enroll, visit the enrollment website at https://portal.adp.com. New users will need the registration pass code: SLPS-ESS.**
- You can make changes online or call the Benefits Call Center at 1-866-345-SLPS (7577).

Table of Contents

Your 2019 Enrollment Materials

Your enrollment packet provides you with general and personalized information to help you make your 2019 elections, along with information on how to enroll online.

Your Packet Contains:

This enrollment guide - Provides an overview of your benefits for 2019, including details on each enrollment decision, information on how to enroll and where to find more information about your benefit options.

Your personal enrollment worksheet - Presents personalized benefits information such as your benefit options and associated premium costs.

Key Dates for Open Enrollment

You can make changes for benefits during the Open Enrollment period - November 18, 2018 through December 1, 2018, CST. If you don't enroll during this period, you will receive default benefits. (See "If You Do Not Enroll" on page 2 for more information.) You will be able to make changes or corrections from December 9, 2018 through December 15, 2018 at Midnight, CST.

The chart below provides more details about the coming weeks.

EVENT	TIMING	WHAT TO EXPECT
Open Enrollment	November 18 - December 1 at Midnight, CST	• Enrollment for Medical, Dental and Vision benefits for you and your dependents. • Enrollment for Supplemental Term Life Insurance for you and your dependents. • Election to participate in the Flexible Spending Accounts. • **Beneficiary Designation Online.**
Confirmation statements arrive at your home	Week of December 2, 2018	• If your confirmation does not reflect your elections for 2019, call the Benefits Call Center phone line at 1-866-345-SLPS (7577).
Corrections	December 9, 2018 through December 15, 2018 at Midnight, CST	• Call before December 15, 2018, Midnight CST to correct any errors or discrepancies with your confirmation statement.
New benefit elections effective	January 1, 2019	• Your new benefits become effective.

How to Enroll

Prepare

Step 1: Read the Employee Benefits Enrollment Guide to learn about important changes to the benefits program for the new Plan Year. Review the benefits plan design and the costs for each benefit plan and consider changes that you want to make during Open Enrollment.

Step 2: Examine your personalized worksheet for current elections. Mark your choice for each plan on your worksheet.

Step 3: Have personal and dependent information available, such as Social Security numbers, birthdates, and bi-weekly amount that you want to contribute to a Flexible Spending Account (FSA) if you are participating.

Access Website

Step 1: Log onto https://portal.adp.com (new users refer to annual enrollment notification for instructions) and select the link "Enroll in 2019 Benefits."

Step 2: Click Continue to find instructions on each screen to guide you through the enrollment process.

Step 3: Complete the security screen before you enter your enrollment selections. You will need your Social Security number and your Personal Identification Number (PIN).

Enroll

Step 1: With your worksheet in hand, choose from the available options on each screen to obtain or complete benefits information.

Step 2: Review Personal Information and Current Dependents sections and update appropriately. Keep in mind that adding dependent information does not automatically enroll your dependents in any coverage. You must still select the plan option and coverage level to enroll your dependents.

Step 3: Continue to follow the instructions and steps to enter your choices for your 2019 benefits.

Confirm

Step 1: When you are finished, click on the Submit button to save your selections.

Step 2: Write down your confirmation number. You have the opportunity to receive an e-mail confirmation - just enter your e-mail address when prompted during the enrollment process.

Step 3: You may also print the Confirmation page to keep a copy for your records.

Step 4: During the week of December 2, 2018, you will receive a statement confirming your final benefits selections for 2019. To make corrections to your selections, simply go back to the website (https://portal.adp.com) as many times as you want beginning December 9, 2018 through December 15, 2018, Midnight, CST.

Step 5: If your confirmation does not reflect your elections for 2019, call the Benefits Call Center, 1-866-345-SLPS (7577), Monday through Friday, 8:00 a.m. to 6:00 p.m. CST and Saturday, 7:00 a.m. to 4:00 p.m.

Step 6: To log off, press Continue at the bottom of the page.

Eligibility

Who is Eligible

You can participate in the SLPS Benefits Plan if you are an eligible employee. The district defines an eligible employee as a full-time permanent employee with a scheduled work week of 30 hours or more. Eligible dependents can participate in some of the benefit plans.

Your eligible dependents may include your:

- Legal spouse (unless legally separated);
- Dependent child until the end of the month in which he or she reaches age 26 (please see definition below);
- The term Child includes any of the following:
  - A natural child.
  - A stepchild.
  - A legally adopted child.
  - A child placed for adoption.
  - A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- To be eligible for coverage under the Policy, a Dependent must reside within the United States.
- The definition of Dependent is subject to the following conditions and limitations:
  - A Dependent includes any child listed above under 26 years of age.
  - A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

If you opt out of medical coverage for yourself or waive coverage for your dependents, you cannot enroll until the next annual enrollment period unless you have a qualified life event or change in status, as described below.

When Coverage Begins

For newly hired or newly eligible employees, coverage is effective the 1st of the month following your hire date or eligibility date.

When You Can Make Changes

In general, you can make changes to your benefits coverage during annual open enrollment. However, you can make changes during the year if you have a qualified life event or change in status. Any changes you make for yourself and your dependents must be consistent with and on account of your change in status. For example, you can enroll your newborn in medical coverage, but you cannot drop coverage for your spouse or change medical options because of the birth of your child.

Qualified life events and changes in status that permit coverage changes are:

- Employee gains a tax dependent, i.e., through birth, legal adoption or placement of a child for adoption
- Marriage
- Divorce, annulment or legal separation
- Dependent who reaches age 26 or no longer meets eligibility requirements
- Spouse gains or loses coverage due to gaining or losing employment/ eligibility with current employer
- Death of a spouse
- Death of a dependent child
- Spouse/dependent becomes Medicare/Medicaid eligible or ineligible
- Dependent loses coverage

Coverage Levels

If you choose to enroll in the Medical and/or Dental Plans, you can elect coverage for:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

For the Vision Plan, you can elect coverage for:

- Employee Only
- Employee + 1 Dependent
- Employee + 2 or More Dependents

For the Supplemental Life Insurance Plan, you can elect coverage for:

- Employee Only
- Spouse
- Children

For the Flexible Spending Accounts, you can elect either or both:

- Healthcare Reimbursement Account
- Dependent Care Reimbursement Account

Cost of Coverage

The District pays the cost for your coverage (employee only) in the Base Medical, Dental and Vision Plans. You pay the full cost for your spouse and dependent children and the difference in cost between Base and Buy-up plans on a pre-tax basis.

The District pays the cost of your coverage (employee only) for Basic Term Life Insurance which includes coverage for AD&D. You pay the cost for your Supplemental Life Insurance on an after-tax basis.

You pay the cost for the Flexible Spending Accounts on a pre-tax basis. See your personal enrollment worksheet for specific cost information.

Change in Status

Listing of Allowable/Non-allowable Changes

The Change in Status charts on the following pages list the changes that you may make to your current benefits if you have a qualified change in status event. ***Note:*** *The plan options for Medical cannot change from one plan to the other, regardless of CIS event.*

If you have a qualified life event, you must make your benefit changes within 30 days of the actual event using the Benefit website, **https://portal.adp.com**. You may also contact the Benefits Call Center at 1-866-345-SLPS (7577), from 8:00 a.m. to 6:00 p.m. CST, Monday through Friday.

Otherwise you cannot make changes until the next benefits enrollment period. Most coverage changes due to a qualified life event or change in status are effective on the event date, if submitted within 30 days of the event. Please refer to the next few pages for a list of allowable changes based on your qualifying event.

Birth or Adoption *(If your newborn has not been assigned a SSN, then please enter your SSN)*		
	Allowed	**Not Allowed**
Medical	Enroll Self Add Spouse Add Children	Drop Self Drop Spouse Drop Children
Dental and Vision	Add Spouse Add Children	Drop Spouse Drop Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	No Limitations - No EOI required	N/A
FSA (both Health and Dependent Care)	Enroll Increase Coverage	Drop Coverage Decrease Coverage
Spouse/Dependent Eligible Medicare/Medicaid/Other Group Coverage*		
	Allowed	**Not Allowed**
Medical	Drop Spouse Drop Children	Enroll or Drop Self Add Spouse Add Children
Dental and Vision	Drop Spouse Drop Children	Add Spouse Add Children
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
Healthcare FSA	Drop Coverage Decrease Coverage	Enroll Increase Coverage
Dependent Care FSA	No Changes Allowed	N/A

***ONLY APPLICABLE TO THE AFFECTED DEPENDENT**

Change in Status

Marriage		
	Allowed	**Not Allowed**
Medical	Enroll or Drop Self Add Spouse Add or Drop Children	Drop Spouse
Dental and Vision	Add Spouse Add or Drop Children	Drop Spouse
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended with exception of $20,000 guarantee with no pend	
Supplemental Life - Child(ren)	No Limitations - No EOI required	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A
Divorce/Annulment/Legal Separation		
	Allowed	**Not Allowed**
Medical	Enroll Self Drop Spouse Add or Drop Children	Drop Self Add Spouse
Dental and Vision	Drop Spouse Add or Drop Children	Add Spouse
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	Drop Only	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A

Change in Status

Spouse/Dependent Gain Employment		
	Allowed	**Not Allowed**
Medical	Drop Self Drop Spouse Drop Child	Enroll Self Add Spouse Add Children
Dental and Vision	Drop Spouse Drop Children	Add Spouse Add Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
Healthcare FSA	Drop Coverage Decrease Coverage	Enroll Increase Coverage
Dependent Care FSA	No Limitations	N/A
Spouse/Dependent Loses Employment		
	Allowed	**Not Allowed**
Medical	Enroll Self Add Spouse Add Child	Drop Self Drop Spouse Drop Children
Dental and Vision	Add Spouse Add or Drop Children	Drop Spouse Drop Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
Healthcare FSA	Enroll Self Increase Coverage	Drop Coverage Decrease Coverage
Dependent Care FSA	No Limitations	N/A

Change in Status

Death of Spouse		
	Allowed	**Not Allowed**
Medical	Enroll Self Drop Spouse Add Children	Drop Self Add Spouse Drop Children
Dental and Vision	Drop Spouse Add Children	Add Spouse Drop Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	Drop Only	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A
Death of Dependent		
	Allowed	**Not Allowed**
Medical	Drop Children	Enroll or Drop Self Add or Drop Spouse Add Children
Dental and Vision	Drop Children	Add or Drop Spouse Add Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
FSA (both Health and Dependent Care)	Drop Coverage Decrease Coverage	Enroll Increase Coverage

Change in Status

Dependent Loss of Coverage (turns age 26)		
	Allowed	**Not Allowed**
Medical	Drop Children	Enroll or Drop Self Add or Drop Spouse Add Children
Dental and Vision	Drop Children	Add or Drop Spouse Add Children
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A
Coverage and Cost changes to Dependent Care FSA		
	Allowed	**Not Allowed**
Medical	No Changes Allowed	N/A
Dental and Vision	No Changes Allowed	N/A
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
FSA - Healthcare	No Changes Allowed	N/A
FSA - Dependent Care	Drop Coverage Increase Coverage Decrease Coverage	N/A
Spouse/Dependent no longer Eligible Medicare/Medicaid/Other Group Coverage*		
	Allowed	**Not Allowed**
Medical	Add Spouse Add Children	Enroll or Drop Self Drop Spouse Drop Children
Dental and Vision	Add Spouse Add Children	Drop Spouse Drop Children
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
FSA - Healthcare	Add Coverage Increase Coverage	Drop Coverage Decrease Coverage
FSA - Dependent Care	No Changes Allowed	N/A

***ONLY APPLICABLE TO THE AFFECTED DEPENDENT**

Medical Plans

Your health care options for 2019 will include a choice of the following:

- UnitedHealthcare Base Choice Plus Plan
- UnitedHealthcare Buy-Up 1 Choice Plus Plan
- UnitedHealthcare Buy-Up 2 Choice Plus Plan
- Opt out of medical coverage

UnitedHealthcare insures and administers both medical plans.

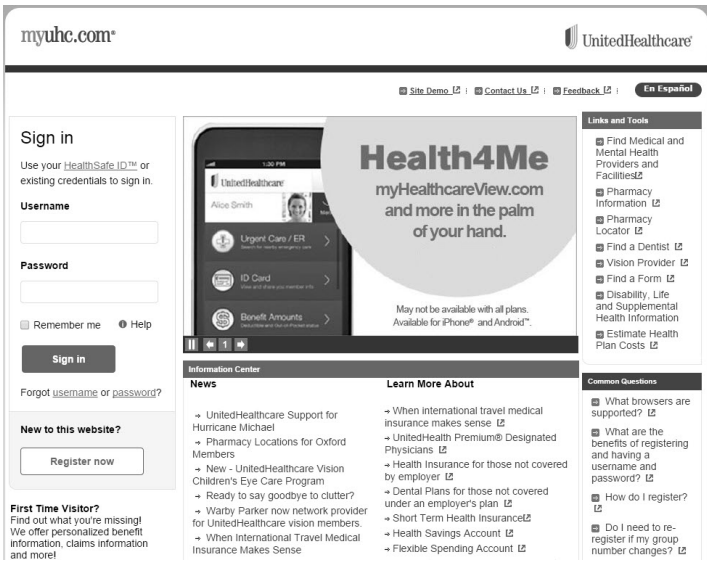
If you choose to opt out of Medical coverage because you have coverage under another plan, you will receive a monthly credit. A credit of $50 per month will be paid to 12-month employees; non-12-month employees receive a $60 monthly credit. This amount will be included in the last paycheck of each month, as taxable wages.

Comparing Your Medical Plan Options

Both UnitedHealthcare Base and UnitedHealthcare Buy Up plans are known as Choice Plus plans. This gives members the ultimate freedom of choice when selecting providers. The following provides details on the differences between selecting an in-network provider vs. an out-of-network provider.

UnitedHealthcare Base Choice Plus Plan

This plan offers in- and out-of-network benefits, and you do not need to choose a primary care physician (PCP) or obtain a referral to see a network specialist. Your cost for care is lower when you use network providers. You can receive care from providers outside of the network, but your share of the cost is higher and you are responsible for paying any expenses that exceed the "Eligible Expense." (The "Eligible Expense" is a percentage of the published rates allowed by Medicare for the same or similar services.) You pay a set fee, or co-payment, for in-network physician office visits under this plan. When you use network providers, you often pay only a co-payment for covered services. Network services have lower deductibles and out-of-pocket costs. However, the co-payments and deductibles are higher for in-network benefits under this plan as compared to the UnitedHealthcare Buy Up Choice Plus Plan.



UnitedHealthcare Buy Up Choice Plus Plans

These plans work similar to the UnitedHealthcare Base Choice Plus plan. Under the UnitedHealthcare Buy-Up 1 and Buy-Up 2 Choice Plus plans, the in-network deductibles are less, the coinsurance amounts are greater. The Buy-Up 2 Choice Plus Plan has the lowest in-network copayments.

After you meet the annual deductible, the plan shares a percentage of covered medical expenses up to the "Eligible Expense" limits. Your share of the expenses is the coinsurance. For hospital stays, surgeries, extensive tests, lab tests and X-rays, you pay your annual deductible, the coinsurance and any separate hospital co-payments or confinement deductibles, if applicable. Once you reach the annual out-of-pocket maximum, the plan pays for certain covered expenses at 100% of "Eligible Expense" limits. Network care expenses are based on the contracted fees with that network provider.

Member website

- Get all your health plan information. In one place.
- **Make informed decisions.** As a member, **myuhc.com** gives you personalized plan information, care choices, budgeting tools and wellness tips – all in one spot. Download the UnitedHealthcare Health4Me® mobile app for on-the-go access.
- **Find and price the care you need.** The find-and-price care tool makes it simple to find a doctor, clinic, hospital, or lab based on location, specialty, reputation, cost of services, availability or hours of operation. You can even see patient ratings and compare quality and costs before you choose services.
- **Know your health care costs.** Get a clear picture of spending. View a snapshot of account activity, benefits received and outstanding balances. Track claims. Easily see the status of your claims.
- **Get and stay healthy.** Discover wellness tools and advice. Tailored to help you live healthier, and get the most from your plan.
- **Achieve your health goals.** Set goals and reach them with individualized recommendations on exercise, diet, therapy and more.
- **Join a healthy-living community.** Connect with other members for support and to share ideas on how to live balanced, healthy and active lives.

Plan Comparisons

The following chart compares your benefits under the UnitedHealthcare Base and UnitedHealthcare Buy-Up plans.

Medical Plan						
	UnitedHealthcare Base Plan		UnitedHealthcare Buy-Up 1 Plan		UnitedHealthcare Buy-Up 2 Plan	
Deductible	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Individual	$1,500	$2,000	$500	$1,000	$200	$400
Family	$3,000	$4,000	$1,000	$2,000	$400	$800
Coinsurance (includes deductible)	70%	60%	80%	70%	90%	70%
Individual Out-of-Pocket Max	$4,000	$7,000	$3,500	$7,000	$1,400	$2,800
Family Out-of-Pocket Max	$8,000	$14,000	$7,000	$14,000	$2,800	$5,600
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Items included in OOP Max	Med & Rx	Deductible	Med & Rx	Deductible	Med & Rx	Deductible
Physician Office Visit						
Covered person under age 19	$0 Copay	60% AD	$0 Copay	70% AD	$0 Copay	70% AD
Physician Office Visit						
Illness/Injury	$25/$35 Copay	60% AD	$25/$35 Copay	70% AD	$15/$30 Copay	70% AD
Virtual Visits	$0 Copay	60% AD	$0 Copay	70% AD	$0 Copay	70% AD
Preventive Care	100%	60% AD	100%	70% AD	100%	70% AD
Hospital Services						
Inpatient	70% AD	60% AD	80% AD	70% AD	90% AD	70% AD
Outpatient	70% AD	60% AD	80% AD	70% AD	90% AD	70% AD
Emergency Care						
Hospital Emergency Room	$250 Copay	$250 Copay	$250 Copay	$250 Copay	$150 Copay	$150 Copay
Urgent Care	$75 Copay	60% AD	$75 Copay	70% AD	$50 Copay	70% AD
Other Services						
Diagnostic X-rays & Lab	100%	60% AD	100%	70% AD	100%	70% AD
Major Diagnostic (CT, MRI, etc.)	70% AD	60% AD	80% AD	70% AD	90% AD	70% AD
Chiropractic Services	$20 Copay	60%	$20 Copay	70%	$20 Copay	70%
Therapy (visit limits apply)	$25 Copay	60% AD	$25 Copay	70% AD	$15 Copay	70% AD

AD = After Deductible

*Non-participating providers may balance bill amounts over plan maximums.

VISION BENEFIT – under your UnitedHealthcare Base and Buy Up Choice Plus Plans

- Routine vision exam every year (including refraction) at your physician office visit co-pay.
- Services must be performed at a Spectera Vision in-network provider, which consists of private practice and retail optical providers.

How to Receive Plan Benefits

Each time you need medical care, you decide the level of benefits by choosing in- or out-of-network providers. If you want in-network benefits, be sure to confirm that your provider is part of the UnitedHealthcare Choice Plus network before you receive care. If your provider is not part of the network, ask if he or she would be willing to join.

To choose a network provider, visit the UnitedHealthcare website at myuhc.com and click on *Find Physician, Laboratory or Facility* at the top of the page.

When you use an in-network provider, you do not have to file a claim - your provider files a claim directly with UnitedHealthcare. Depending on the type of service you receive, you will pay a co-payment amount or coinsurance and the plan pays the remaining covered amount. When you use an out-of-network provider, you may have to pay the full cost to the provider and file a claim to be reimbursed for a percentage of the covered expenses for medically necessary services, after you meet your annual deductible.

UnitedHealthcare Base Choice Plus Plan

UnitedHealthcare Base Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

This Summary of Benefits summarizes your obligation towards the cost of certain covered services. Refer to your Certificate of Coverage (COC) for a detailed description of covered services and limitations or exclusions.

To receive In-Network benefits, all covered services, except for Emergency Health Services, must be performed or referred by a participating UnitedHealthcare Choice Plus provider or authorized in advance by the Plan.

All services must be medically necessary as a condition of coverage and not otherwise limited or excluded.

Some of the Important Benefits of Your Plan:

- You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.
- Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.
- Transition of care services are available to help identify and prevent delays in care for those who might need specialized help.
- Pap smears are covered.
- Prenatal care is covered.
- Routine check-ups are covered.
- Childhood immunizations are covered.
- Mammograms are covered.
- Vision and hearing screenings are covered.

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 1-844-298-8930.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 atwww.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 Non-Network: **$2,000** Individual / **$4,000** 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 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 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: **$4,000** Individual / **$8,000** Family Non-Network: **$7,000** Individual / **$14,000** 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 myuhc.com or call **1-844-298-8930** 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)	Non-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	$25 copay per visit, deductible does not apply.	40% coinsurance	Virtual visits (Telehealth) - No Charge by a Designated Virtual Network Provider, If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. Under age 19 - Network visits are covered at No Charge.
	Specialist visit	$35 copay per visit, deductible does not apply.	30% 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	40% 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.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% coinsurance	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest Cost Option	Not Covered	Not Covered	No coverage for prescription drugs with UnitedHealthcare.
	Tier 2 – Your Mid-Range Cost Option	Not Covered	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Not Covered	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay per visit, deductible does not apply.	$250 copay per visit, deductible does not apply.	None
	Emergency medical transportation	30% coinsurance	*30% coinsurance	*Network deductible applies

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Urgent care	$75 copay per visit, deductible does not apply.	40% coinsurance	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay per visit, deductible does not apply.	40% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 30% coinsurance. Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	30% coinsurance	40% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office visits	No Charge	40% coinsurance	Cost sharing does not apply for preventive services. 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 professional services	30% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	Inpatient preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	$25 copay per visit, deductible does not apply.	40% coinsurance	Limits per calendar year: Physical/Occupational: combined limit 60 visits; Speech: Unlimited visits; Cardiac: 36 visits; Pulmonary: 36 visits. No limits apply for treatment of Autism Spectrum Disorder Services.
	Habilitative services	$25 copay per visit, deductible does not apply.	40% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of Autism Spectrum Disorder Services. Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled Nursing is limited to 45 days per calendar year. Inpatient rehabilitation limited to 60 days. Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Durable medical	30% coinsurance	40% coinsurance	Covers 1 per type of DME (including repair/replacement) every 5 years.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	equipment			Preauthorization is required non-network for DME over $1,000 or no coverage.
	Hospice services	30% coinsurance	40% coinsurance	Preauthorization is required before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	$25 copay per visit, deductible does not apply.	40% coinsurance	Limited to 1 exam every 12 months.
	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 travelling outside - the U.S.
- Prescription drugs
- Private duty nursing
- 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)
- Hearing aids
- Routine eye care (adult) - 1 exam per 12 months

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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 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 Missouri Department of Insurance at 1-800-726-7390 or insurance.mo.gov.

Additionally, a consumer assistance program may help you file your appeal. Contact Health Help Missouri Department of Insurance at 1-800-726-7390 or insurance.mo.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-844-298-8930.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-298-8930.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-844-298-8930.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-298-8930.

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

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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)		**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$1,500**	■ **The plan's overall deductible**	**$1,500**	■ **The plan's overall deductible**	**$1,500**
■ **Specialist copay**	**$35**	■ **Specialist copay**	**$35**	■ **Specialist copay**	**$35**
■ **Hospital (facility) coinsurance**	**30%**	■ **Hospital (facility) coinsurance**	**30%**	■ **Hospital (facility) coinsurance**	**30%**
■ **Other coinsurance**	**30%**	■ **Other coinsurance**	**30%**	■ **Other coinsurance**	**30%**
This EXAMPLE event includes services like: Specialist office visits (*prenatal care)* Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (*ultrasounds and blood work)* Specialist visit *(anesthesia)*		**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)*		**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	**$12,800**	**Total Example Cost**	**$7,400**	**Total Example Cost**	**$1,900**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$1,500	Deductibles	$200	Deductibles	$750
Copayments	$0	Copayments	$200	Copayments	$400
Coinsurance	$2,500	Coinsurance	$0	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$100	Limits or exclusions	$6,000	Limits or exclusions	$0
The total Peg would pay is	**$4,100**	**The total Joe would pay is**	**$6,400**	**The total Mia would pay is**	**$1,150**

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

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية هذا (Summary of Benefits and Coverage، SBC).

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」(Summary of Benefits and Coverage, SBC)に記載されているフリーダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

UnitedHealthcare®

Benefit Summary

Missouri - Choice Plus
Traditional with Deductible - Plan AQIL Mod.

SLPS Base

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the Choice Plus Plan?

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com**® and on the go with the **UnitedHealthcare Health4Me**® mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.comlchoiceplus** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
$25	$1,500	30%

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

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Annual Deductible		
What is an annual deductible?		
The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.		
> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	$1,500 per year	$2,000 per year
Medical Deductible - Family	$3,000 per year	$4,000 per year
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.		
> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$4,000 per year	$7,000 per year
Out-of-Pocket Limit - Family	$8,000 per year	$14,000 per year

Your Costs

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 30%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $25). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ambulance Services		
Emergency Ambulance	30% co-insurance, after the medical deductible has been met.	30% co-insurance, after the network medical deductible has been met.
Non-Emergency Ambulance	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorders Treatment		
No visit limits apply for Therapeutic Care for the Treatment of Autism Spectrum Disorders, including but not limited to Habilitative or Rehabilitative Care.	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for Autism Spectrum Disorders Treatment during a Physician's office visit will be the same as found under Physician's Office - Sickness and Injury in this Benefit Summary. Benefits for Therapeutic Treatments for Autism Spectrum Disorders will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for pharmaceutical products received on an outpatient basis for Autism Spectrum Disorders Treatment will be the same as found under Pharmaceutical Products - Outpatient in this Benefit Summary.	Prior Authorization is required.
Chiropractic Services		
Co-insurance will not exceed 50% of the total cost of any single chiropractic service provided within the scope of a chiropractor's license as defined by Missouri law.	$20 co-pay per visit. A deductible does not apply.	40% co-insurance. A deductible does not apply.
Clinical Trials		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental Anesthesia and Facility Charges		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for dental anesthesia received during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for dental anesthesia received on an outpatient basis will be the same as found under Surgery - Outpatient in this Benefit Summary. Benefits for Physician fees for dental anesthesia and facility charges will be the same as found under Physician Fees for Surgical and Medical Services in this Benefit Summary.	
		Prior Authorization is required.
Dental Services - Accident Only		
	30% co-insurance, after the medical deductible has been met.	30% co-insurance, after the network medical deductible has been met.
	Prior Authorization is required.	Prior Authorization is required.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.	
Diabetes Self Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Outpatient Prescription Drug Rider.	
		Prior Authorization is required for DME that costs more than $1,000.
Durable Medical Equipment (DME), Orthotics and Supplies		
Limited to a single purchase of a type of DME or orthotic every five years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for DME or orthotics that costs more than $1,000.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Early Intervention Services		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for early intervention services that are considered Durable Medical Equipment will be the same as found under Durable Medical Equipment in this Benefit Summary. Benefits for early intervention services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for early intervention services that are considered rehabilitation services will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary.	
		Prior Authorization is required.
Emergency Health Care Services - Outpatient		
	$250 co-pay per visit. A deductible does not apply. (Waived if patient is admitted.)	$250 co-pay per visit. A deductible does not apply. (Waived if patient is admitted.) Notification is required if confined in an Out-of-Network Hospital.
Gender Dysphoria		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Habilitative Services		
Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Post-cochlear implant aural therapy. Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services - Outpatient Therapy. Limits do not apply to Therapeutic Care for the Treatment of Autism Spectrum Disorder, Early Intervention Services, Chiropractic Services, or Speech therapy.	$25 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Hearing Aids		
Limited to a single purchase per hearing impaired ear every five years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Hearing Screening for Newborns		
	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Home Health Care		
To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Human Leukocyte Testing		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for laboratory tests related to human leukocyte testing will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. Benefits for human leukocyte testing during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.	
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient	You pay nothing. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	You pay nothing. A deductible does not apply.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Major Diagnostic and Imaging - Outpatient		
	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Medical Foods		
	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Outpatient:	$20 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Ostomy Supplies		
	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	30% co-insurance, after the medical deductible has been met, except when provided during a physician office visit.	40% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
	Covered persons less than age 19: You pay nothing for a primary care physician office visit. A deductible does not apply. All other Covered Persons: $25 co-pay per visit for a primary care physician office visit. A deductible does not apply. $35 co-pay per visit for a specialist office visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for Genetic Testing.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A medical deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Rehabilitation Services - Outpatient Therapy		
Limited to: 60 visits of any combination of physical and occupation therapy. 36 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. Limits do not apply to Therapeutic Care for Treatment of Autism Spectrum Disorder, Early Intervention Services, Chiropractic Services, Speech therapy, or pulmonary rehabilitation therapy.	$25 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility I Inpatient Rehabilitation Facility Services		
Limited to 45 days per year in a skilled nursing facility. Limited to 60 days per year in an inpatient rehab facility.	20% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Speech and Hearing Services		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for speech and hearing therapy related to rehabilitation will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for speech and hearing services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for lab, x-ray and diagnostic services related to speech and hearing testing will be the same as found under Lab, X-ray and Diagnostics - Outpatient in this Benefit Summary.	

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Surgery - Outpatient		
	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Telehealth		
	The amount you pay is based on where the covered health care service is provided.	
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	30% co-insurance, after the medical deductible has been met.	40% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$75 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	You pay nothing. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.
Vision Exams		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every 12 months.	$25 co-pay per visit. A deductible does not apply.	40% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; adventure-based therapy, wilderness therapy, outdoor therapy or similar programs, art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in Section 1: COC.

Autism Spectrum Disorders Treatment

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Educational services that are focused on mainly building skills and capabilities in communication, social interaction and learning. This exclusion does not apply to Benefits described under Autism Spectrum Disorders Treatment in Section 1 of the COC consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions shown in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for, by the school under the Individuals with Disabilities Education Act. Transitional Living services.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia, except as described under Dental Anesthesia and Facility Charges in Section 1 of the COC). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate, diseases of the mouth and if injury to the tooth was a serious injury as described under Dental Services - Accident Only in Section 1 of the COC. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: removal, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Services your plan does not cover (Exclusions)

Devices, Appliances and Prosthetics

Devices used as safety items or to help performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Cranial banding. This exclusion does not apply to items needed for the medically appropriate treatment for the diagnosis of congenital defects or birth abnormalities. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses, and ultrasonic nebulizers. Devices and computers to help in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. This exclusion does not apply to assistive technology devices for children from birth to age three who are eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431. Oral appliances for snoring. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician’s office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician’s office. Over-the-counter drugs and treatments. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Services your plan does not cover (Exclusions)

Gender Dysphoria

Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices in Section 1 of the COC. This exception does not apply to supplies for the administration of medical food products.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC

Tubing and masks except when used with DME as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health Care and Substance-Related and Addictive Disorders

Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to Benefits described under Autism Spectrum Disorders Treatment in Section 1 of the COC consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions shown in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act. Transitional Living services.

Nutrition

Individual and group nutritional counseling including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula and donor breast milk. This exclusion does not apply to Medical Foods for Covered Persons, for which Benefits are provided as described under Medical Foods or Mental Health Care and Substance-Related and Addictive Disorders Services in Section 1 of the COC. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes. This exclusion does not apply to Medical Foods for Covered Persons, for which Benefits are provided as described under Medical Foods or Mental Health Care and Substance-Related and Addictive Disorders Services in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness or flexibility. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs.

Procedures and Treatments

Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment. This does not apply to Autism Spectrum Disorder. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder. Habilitative services for maintenance/preventive treatment. This does not apply to Benefits which are provided as described under Autism Spectrum Disorder Services or Early Intervention Services in Section 1 of the COC. Outpatient cognitive rehabilitation therapy except for long term or progressive conditions such as following a post-traumatic brain Injury, cerebral vascular accident, cerebral palsy, Alzheimer's disease, Parkinson's disease or stroke. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. Helicobacter pylori (H. pylori) serologic testing.

Services your plan does not cover (Exclusions)

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal address. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider has not been involved in your medical care prior to ordering the service, or is not involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. Gestational carrier (surrogate parenting), donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health care services during active military duty.

Transplants

Health care services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient’s Benefits under the Policy.) Health care services for transplants involving permanent mechanical or animal organs.

Travel

Health care services provided in a foreign country, unless required as Emergency Health Care Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care aides. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Services your plan does not cover (Exclusions)

Vision and Hearing

Cost and fitting charge for eyeglasses and contact lenses. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid. You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than formalfunctions.

All Other Exclusions

Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Care Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when: required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders. (This exclusion does not apply to services that are determined to be Medically Necessary). Conducted for purposes of medical research (This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to get or maintain a license of any type. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended. This exclusion does not apply if you are eligible for and choose continuation coverage or if you are eligible for extended coverage for Total Disability. For more information refer to Section 4 of the COC. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy. In the event an out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the co-payments, co-insurance and/or deductible arewaived. Charges in excess of the Allowed Amount or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service. This exclusion does not apply to services covered under Emergency Health Care Services. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease orcondition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

For Internal Use only:
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Item#	**Rev. Date**	
350-8889	0318	Base/Value/Sep/Emb/35435/2018

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

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

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

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

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

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

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

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

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

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

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

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

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

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

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

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

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ़्री फ़ोन नंबर पर काल करें।

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានទៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

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

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

UnitedHealthcare Buy-Up 1 Choice Plus Plan

UnitedHealthcare Buy-Up 1 Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

This Summary of Benefits summarizes your obligation towards the cost of certain covered services. Refer to your Certificate of Coverage (COC) for a detailed description of covered services and limitations or exclusions.

To receive In-Network benefits, all covered services, except for Emergency Health Services, must be performed or referred by a participating UnitedHealthcare Choice Plus provider or authorized in advance by the Plan.

All services must be medically necessary as a condition of coverage and not otherwise limited or excluded.

Some of the Important Benefits of Your Plan:

- You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.
- Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.
- Transition of care services are available to help identify and prevent delays in care for those who might need specialized help.
- Pap smears are covered.
- Prenatal care is covered.
- Routine check-ups are covered.
- Childhood immunizations are covered.
- Mammograms are covered.
- Vision and hearing screenings are covered.

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 1-844-298-8930.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 atwww.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: **$500** Individual / **$1,000** Family Non-Network: **$1,000** Individual / **$2,000** 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 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 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 Non-Network: **$7,000** Individual / **$14,000** 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 myuhc.com or call **1-844-298-8930** 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)	Non-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	$25 copay per visit, deductible does not apply.	30% coinsurance	Virtual visits (Telehealth) - No Charge by a Designated Virtual Network Provider, If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. Under age 19 - Network visits are covered at No Charge.
	Specialist visit	$35 copay per visit, deductible does not apply.	30% 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	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.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest Cost Option	Not Covered	Not Covered	No coverage for prescription drugs with UnitedHealthcare.
	Tier 2 – Your Mid-Range Cost Option	Not Covered	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Not Covered	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay per visit, deductible does not apply.	$250 copay per visit, deductible does not apply.	None
	Emergency medical transportation	20% coinsurance	*20% coinsurance	*Network deductible applies

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Urgent care	$75 copay per visit, deductible does not apply.	30% coinsurance	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit, deductible does not apply.	30% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 20% coinsurance. Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	20% coinsurance	30% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount. 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. 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 professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	Inpatient preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	$25 copay per visit, deductible does not apply.	30% coinsurance	Limits per calendar year: Physical/Occupational: combined limit 60 visits; Speech: Unlimited visits; Cardiac: 36 visits; Pulmonary: 36 visits. No limits apply for treatment of Autism Spectrum Disorder Services.
	Habilitative services	$25 copay per visit, deductible does not apply.	30% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of Autism Spectrum Disorder Services. Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount.
	Skilled nursing care	20% coinsurance	30% coinsurance	Skilled Nursing is limited to 45 days per calendar year. Inpatient rehabilitation limited to 60 days. Preauthorization is required non-network or benefit reduces to 50% of allowed amount.

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	30% coinsurance	Covers 1 per type of DME (including repair/replacement) every 5 years. Preauthorization is required non-network for DME over $1,000 or no coverage.
	Hospice services	20% coinsurance	30% coinsurance	Preauthorization is required before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	$25 copay per visit, deductible does not apply.	30% coinsurance	Limited to 1 exam every 12 months.
	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 travelling outside - the U.S.
- Prescription drugs
- Private duty nursing
- 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)
- Hearing aids
- Routine eye care (adult) - 1 exam per 12 months

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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 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 Missouri Department of Insurance at 1-800-726-7390 or insurance.mo.gov.

Additionally, a consumer assistance program may help you file your appeal. Contact Health Help Missouri Department of Insurance at 1-800-726-7390 or insurance.mo.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-844-298-8930.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-298-8930.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-844-298-8930.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-298-8930.

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

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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**	**$500**
■ **Specialist copay**	**$35**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$2,600**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$6,000
The total Joe would pay is	**$6,400**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$960**

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

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

UnitedHealthcare®

Benefit Summary

Missouri - Choice Plus
Traditional with Deductible - Plan AQIL Mod.

SLPS Buy Up 1

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the Choice Plus Plan?

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me®** mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.comIchoiceplus** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
$25	$500	20%

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

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Annual Deductible		
What is an annual deductible?		
The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.		
> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	$500 per year	$1,000 per year
Medical Deductible - Family	$1,000 per year	$2,000 per year
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.		
> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$3,500 per year	$7,000 per year
Out-of-Pocket Limit - Family	$7,000 per year	$14,000 per year

Your Costs

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $25). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ambulance Services		
Emergency Ambulance	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
Non-Emergency Ambulance	20% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorders Treatment		
No visit limits apply for Therapeutic Care for the Treatment of Autism Spectrum Disorders, including but not limited to Habilitative or Rehabilitative Care.	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for Autism Spectrum Disorders Treatment during a Physician's office visit will be the same as found under Physician's Office - Sickness and Injury in this Benefit Summary. Benefits for Therapeutic Treatments for Autism Spectrum Disorders will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for pharmaceutical products received on an outpatient basis for Autism Spectrum Disorders Treatment will be the same as found under Pharmaceutical Products - Outpatient in this Benefit Summary.	Prior Authorization is required.
Chiropractic Services		
Co-insurance will not exceed 50% of the total cost of any single chiropractic service provided within the scope of a chiropractor's license as defined by Missouri law.	$20 Co-pay per visit. A deductible does not apply.	30% co-insurance. A deductible does not apply.
Clinical Trials		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental Anesthesia and Facility Charges		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for dental anesthesia received during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for dental anesthesia received on an outpatient basis will be the same as found under Surgery - Outpatient in this Benefit Summary. Benefits for Physician fees for dental anesthesia and facility charges will be the same as found under Physician Fees for Surgical and Medical Services in this Benefit Summary.	
		Prior Authorization is required.
Dental Services - Accident Only		
	20% co-insurance, after the medical deductible has been met.	20% co-insurance, after the network medical deductible has been met.
	Prior Authorization is required.	Prior Authorization is required.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.	
Diabetes Self Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Outpatient Prescription Drug Rider.	
		Prior Authorization is required for DME that costs more than $1,000.
Durable Medical Equipment (DME), Orthotics and Supplies		
Limited to a single purchase of a type of DME or orthotic every five years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for DME or orthotics that costs more than $1,000.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Early Intervention Services		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for early intervention services that are considered Durable Medical Equipment will be the same as found under Durable Medical Equipment in this Benefit Summary. Benefits for early intervention services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for early intervention services that are considered rehabilitation services will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary.	Prior Authorization is required.
Emergency Health Care Services - Outpatient		
	$250 co-pay per visit. A deductible does not apply.	$250 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.
Gender Dysphoria		
	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required for certain services.	Prior Authorization is required for certain services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Habilitative Services		
Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Post-cochlear implant aural therapy. Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services - Outpatient Therapy. Limits do not apply to Therapeutic Care for the Treatment of Autism Spectrum Disorder, Early Intervention Services, Chiropractic Services, or Speech therapy.	$25 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Hearing Aids		
Limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Hearing Screening for Newborns		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Home Health Care		
To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Human Leukocyte Testing		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for laboratory tests related to human leukocyte testing will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. Benefits for human leukocyte testing during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.	
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Major Diagnostic and Imaging - Outpatient		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Medical Foods		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$25 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Ostomy Supplies		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	20% co-insurance, after the medical deductible has been met, except when provided during a physician office visit.	30% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
	Covered persons less than age 19: You pay nothing for a primary care physician office visit. A deductible does not apply. All other Covered Persons: $25 co-pay per visit for a primary care physician office visit. A deductible does not apply. $35 co-pay per visit for a specialist office visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Genetic Testing.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A medical deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided.	
		Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Rehabilitation Services - Outpatient Therapy		
Limited to: 60 visits of any combination of Physical therapy and occupational therapy. 36 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. Limits do not apply to Therapeutic Care for Treatment of Autism Spectrum Disorder, Early Intervention Services, Chiropractic Services, Speech therapy, or pulmonary rehabilitation therapy.	$25 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility I Inpatient Rehabilitation Facility Services		
Limited to 45 days per year in a skilled nursing facility. Limited to 60 days per year in an inpatient rehab facility.	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Speech and Hearing Services		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for speech and hearing therapy related to rehabilitation will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for speech and hearing services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for lab, x-ray and diagnostic services related to speech and hearing testing will be the same as found under Lab, X-ray and Diagnostics - Outpatient in this Benefit Summary.	

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Surgery - Outpatient		
	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Telehealth		
	The amount you pay is based on where the covered health care service is provided.	
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	20% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$75 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Vision Exams		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every 12 months.	$25 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; adventure-based therapy, wilderness therapy, outdoor therapy or similar programs, art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in Section 1: COC.

Autism Spectrum Disorders Treatment

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Educational services that are focused on mainly building skills and capabilities in communication, social interaction and learning. This exclusion does not apply to Benefits described under Autism Spectrum Disorders Treatment in Section 1 of the COC consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions shown in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for, by the school under the Individuals with Disabilities Education Act. Transitional Living services.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia, except as described under Dental Anesthesia and Facility Charges in Section 1 of the COC). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate, diseases of the mouth and if injury to the tooth was a serious injury as described under Dental Services - Accident Only in Section 1 of the COC. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: removal, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Services your plan does not cover (Exclusions)

Devices, Appliances and Prosthetics

Devices used as safety items or to help performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Cranial banding. This exclusion does not apply to items needed for the medically appropriate treatment for the diagnosis of congenital defects or birth abnormalities. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses, and ultrasonic nebulizers. Devices and computers to help in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. This exclusion does not apply to assistive technology devices for children from birth to age three who are eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431. Oral appliances for snoring. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Services your plan does not cover (Exclusions)

Gender Dysphoria

Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices in Section 1 of the COC. This exception does not apply to supplies for the administration of medical food products.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC

Tubing and masks except when used with DME as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health Care and Substance-Related and Addictive Disorders

Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to Benefits described under Autism Spectrum Disorders Treatment in Section 1 of the COC consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions shown in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act. Transitional Living services.

Nutrition

Individual and group nutritional counseling including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula and donor breast milk. This exclusion does not apply to Medical Foods for Covered Persons, for which Benefits are provided as described under Medical Foods or Mental Health Care and Substance-Related and Addictive Disorders Services in Section 1 of the COC. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes. This exclusion does not apply to Medical Foods for Covered Persons, for which Benefits are provided as described under Medical Foods or Mental Health Care and Substance-Related and Addictive Disorders Services in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness or flexibility. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs.

Procedures and Treatments

Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment. This does not apply to Autism Spectrum Disorder. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder. Habilitative services for maintenance/preventive treatment. This does not apply to Benefits which are provided as described under Autism Spectrum Disorder Services or Early Intervention Services in Section 1 of the COC. Outpatient cognitive rehabilitation therapy except for long term or progressive conditions such as following a post-traumatic brain Injury, cerebral vascular accident, cerebral palsy, Alzheimer's disease, Parkinson's disease or stroke. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. Helicobacter pylori (H. pylori) serologic testing.

Services your plan does not cover (Exclusions)

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal address. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider has not been involved in your medical care prior to ordering the service, or is not involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. Gestational carrier (surrogate parenting), donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health care services during active military duty.

Transplants

Health care services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient’s Benefits under the Policy.) Health care services for transplants involving permanent mechanical or animal organs.

Travel

Health care services provided in a foreign country, unless required as Emergency Health Care Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care aides. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Services your plan does not cover (Exclusions)

Vision and Hearing

Cost and fitting charge for eyeglasses and contact lenses. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid. You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Care Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when: required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders. (This exclusion does not apply to services that are determined to be Medically Necessary). Conducted for purposes of medical research (This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to get or maintain a license of any type. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended. This exclusion does not apply if you are eligible for and choose continuation coverage or if you are eligible for extended coverage for Total Disability. For more information refer to Section 4 of the COC. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy. In the event an out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the co-payments, co-insurance and/or deductible are waived. Charges in excess of the Allowed Amount or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service. This exclusion does not apply to services covered under Emergency Health Care Services. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

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

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

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

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

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

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

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

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

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

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

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

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

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

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

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

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ़्री फ़ोन नंबर पर काल करें।

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

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

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

UnitedHealthcare Buy-Up 2 Choice Plus Plan

UnitedHealthcare Buy-Up 2 Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

This Summary of Benefits summarizes your obligation towards the cost of certain covered services. Refer to your Certificate of Coverage (COC) for a detailed description of covered services and limitations or exclusions.

To receive In-Network benefits, all covered services, except for Emergency Health Services, must be performed or referred by a participating UnitedHealthcare Choice Plus provider or authorized in advance by the Plan.

All services must be medically necessary as a condition of coverage and not otherwise limited or excluded.

Some of the Important Benefits of Your Plan:

- You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.
- Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.
- Transition of care services are available to help identify and prevent delays in care for those who might need specialized help.
- Pap smears are covered.
- Prenatal care is covered.
- Routine check-ups are covered.
- Childhood immunizations are covered.
- Mammograms are covered.
- Vision and hearing screenings are covered.

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 1-844-298-8930.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: **$200** Individual / **$400** Family Non-Network: **$400** Individual / **$800** 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 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 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: **$1,400** Individual / **$2,800** Family Non-Network: **$2,800** Individual / **$5,600** 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 myuhc.com or call **1-844-298-8930** 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)	Non-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	$15 copay per visit, deductible does not apply.	30% coinsurance	Virtual visits (Telehealth) - No Charge by a Designated Virtual Network Provider, If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery. Under age 19 - Network visits are covered at No Charge.
	Specialist visit	$30 copay per visit, deductible does not apply.	30% 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	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.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest Cost Option	Not Covered	Not Covered	No coverage for prescription drugs with UnitedHealthcare.
	Tier 2 – Your Mid-Range Cost Option	Not Covered	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Not Covered	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay per visit, deductible does not apply.	$150 copay per visit, deductible does not apply.	None
	Emergency medical	10% coinsurance	*10% coinsurance	*Network deductible applies

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	transportation			
	Urgent care	$50 copay per visit, deductible does not apply.	30% coinsurance	If you receive services in addition to Urgent care visit, additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay per visit, deductible does not apply.	30% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 10% coinsurance. Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount. See your policy or plan document for additional information about EAP benefits.
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount. 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. 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 professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	Inpatient preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	$15 copay per visit, deductible does not apply.	30% coinsurance	Limits per calendar year: Physical/Occupational: combined limit 60 visits; Speech: Unlimited visits; Cardiac: 36 visits; Pulmonary: 36 visits. No limits apply for treatment of Autism Spectrum Disorder Services.
	Habilitative services	$15 copay per visit, deductible does not apply.	30% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above No limits apply for treatment of Autism Spectrum Disorder Services. Preauthorization required non-network for certain services or benefit reduces to 50% of

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				allowed amount.
	Skilled nursing care	10% coinsurance	30% coinsurance	Skilled Nursing is limited to 45 days per calendar year. Inpatient rehabilitation limited to 60 days. Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	10% coinsurance	30% coinsurance	Covers 1 per type of DME (including repair/replacement) every 5 years. Preauthorization is required non-network for DME over $1,000 or no coverage.
	Hospice services	10% coinsurance	30% coinsurance	Preauthorization is required before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	$15 copay per visit, deductible does not apply.	30% coinsurance	Limited to 1 exam every 12 months.
	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 travelling outside - the U.S.
- Prescription drugs
- Private duty nursing
- 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)
- Hearing aids
- Routine eye care (adult) - 1 exam per 12 months

* For more information about limitations and exceptions, see the plan or policy document at welcometouhc.com.

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 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 Missouri Department of Insurance at 1-800-726-7390 or insurance.mo.gov.

Additionally, a consumer assistance program may help you file your appeal. Contact Health Help Missouri Department of Insurance at 1-800-726-7390 or insurance.mo.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-844-298-8930.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-298-8930.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-844-298-8930.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-298-8930.

——————————*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)		**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$200**	■ **The plan's overall deductible**	**$200**	■ **The plan's overall deductible**	**$200**
■ **Specialist copay**	**$30**	■ **Specialist copay**	**$30**	■ **Specialist copay**	**$30**
■ **Hospital (facility) coinsurance**	**10%**	■ **Hospital (facility) coinsurance**	**10%**	■ **Hospital (facility) coinsurance**	**10%**
■ **Other coinsurance**	**10%**	■ **Other coinsurance**	**10%**	■ **Other coinsurance**	**10%**
This EXAMPLE event includes services like: Specialist office visits (*prenatal care)* Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (*ultrasounds and blood work)* Specialist visit *(anesthesia)*		**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)*		**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	**$12,800**	**Total Example Cost**	**$7,400**	**Total Example Cost**	**$1,900**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$200	Deductibles	$200	Deductibles	$200
Copayments	$0	Copayments	$100	Copayments	$200
Coinsurance	$1,000	Coinsurance	$0	Coinsurance	$60
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$100	Limits or exclusions	$6,000	Limits or exclusions	$0
The total Peg would pay is	**$1,300**	**The total Joe would pay is**	**$6,300**	**The total Mia would pay is**	**$460**

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

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

UnitedHealthcare®

Benefit Summary

Missouri - Choice Plus
Traditional with Deductible - Plan AQIK Mod.

SLPS Buy Up 2

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the Choice Plus Plan?

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the network.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Are you a member?

Easily manage your benefits online at **myuhc.com**® and on the go with the **UnitedHealthcare Health4Me**® mobile app.

For questions, call the member phone number on your health plan ID card.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choiceplus** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment	Individual Deductible	Co-insurance
(Your cost for an office visit)	(Your cost before the plan starts to pay)	(Your cost share after the deductible)
$15	$200	10%

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

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Annual Deductible		
What is an annual deductible?		
The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.		
> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific covered health care service.		
> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Medical Deductible - Individual	$200 per year	$400 per year
Medical Deductible - Family	$400 per year	$800 per year
Out-of-Pocket Limit		
What is an out-of-pocket limit?		
The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.		
> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.		
> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.		
Out-of-Pocket Limit - Individual	$1,400 per year	$2,800 per year
Out-of-Pocket Limit - Family	$2,800 per year	$5,600 per year

Your Costs

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 10%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $15). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Ambulance Services		
Emergency Ambulance	10% co-insurance, after the medical deductible has been met.	10% co-insurance, after the network medical deductible has been met.
Non-Emergency Ambulance	10% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Autism Spectrum Disorders Treatment		
No visit limits apply for Therapeutic Care for the Treatment of Autism Spectrum Disorders, including but not limited to Habilitative or Rehabilitative Care.	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for Autism Spectrum Disorders Treatment during a Physician's office visit will be the same as found under Physician's Office - Sickness and Injury in this Benefit Summary. Benefits for Therapeutic Treatments for Autism Spectrum Disorders will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for pharmaceutical products received on an outpatient basis for Autism Spectrum Disorders Treatment will be the same as found under Pharmaceutical Products - Outpatient in this Benefit Summary.	Prior Authorization is required.
Chiropractic Services		
Co-insurance will not exceed 50% of the total cost of any single chiropractic service provided within the scope of a chiropractor's license as defined by Missouri law.	$20 Co-pay per visit. A deductible does not apply.	50% co-insurance. A deductible does not apply.
Clinical Trials		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required.	Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Dental Anesthesia and Facility Charges		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for dental anesthesia received during an Inpatient Stay in a Hospital will be the same as found under Hospital - Inpatient Stay in this Benefit Summary. Benefits for dental anesthesia received on an outpatient basis will be the same as found under Surgery - Outpatient in this Benefit Summary. Benefits for Physician fees for dental anesthesia and facility charges will be the same as found under Physician Fees for Surgical and Medical Services in this Benefit Summary.	
		Prior Authorization is required.
Dental Services - Accident Only		
	10% co-insurance, after the medical deductible has been met.	10% co-insurance, after the network medical deductible has been met.
	Prior Authorization is required.	Prior Authorization is required.
Diabetes Services		
Diabetes Self Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.	
Diabetes Self Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Outpatient Prescription Drug Rider.	
		Prior Authorization is required for DME that costs more than $1,000.
Durable Medical Equipment (DME), Orthotics and Supplies		
Limited to a single purchase of a type of DME or orthotic every five years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for DME or orthotics that costs more than $1,000.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Early Intervention Services		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for early intervention services that are considered Durable Medical Equipment will be the same as found under Durable Medical Equipment in this Benefit Summary. Benefits for early intervention services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for early intervention services that are considered rehabilitation services will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary.	
		Prior Authorization is required.
Emergency Health Care Services - Outpatient		
	$150 co-pay per visit. A deductible does not apply.	$150 co-pay per visit. A deductible does not apply.
		Notification is required if confined in an Out-of-Network Hospital.
Gender Dysphoria		
	The amount you pay is based on where the covered health care service is provided.	
	Prior Authorization is required for certain services.	Prior Authorization is required for certain services.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Habilitative Services		
Inpatient: Inpatient services limited per year as follows: Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services.	The amount you pay is based on where the covered health care service is provided.	
Outpatient: Outpatient therapies: Physical therapy. Occupational therapy. Post-cochlear implant aural therapy. Cognitive therapy. For the above outpatient therapies: Limits will be the same as, and combined with, those stated under Rehabilitation Services - Outpatient Therapy. Limits do not apply to Therapeutic Care for the Treatment of Autism Spectrum Disorder, Early Intervention Services, Chiropractic Services, or Speech therapy.	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Hearing Aids		
Limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Hearing Screening for Newborns		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Home Health Care		
To receive Network Benefits for the administration of intravenous infusion, you must receive services from a provider we identify.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Human Leukocyte Testing		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for laboratory tests related to human leukocyte testing will be the same as found under Lab, X-Ray and Diagnostics - Outpatient in this Benefit Summary. Benefits for human leukocyte testing during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary.	
Lab, X-Ray and Diagnostic - Outpatient		
Lab Testing - Outpatient	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Major Diagnostic and Imaging - Outpatient		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Medical Foods		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Mental Health Care and Substance - Related and Addictive Disorders Services		
Inpatient:	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Ostomy Supplies		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	10% co-insurance, after the medical deductible has been met, except when provided during a physician office visit.	30% co-insurance, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury		
	Covered persons less than age 19: You pay nothing for a primary care physician office visit. A deductible does not apply. All other Covered Persons: $15 co-pay per visit for a primary care physician office visit. A deductible does not apply. $30 co-pay per visit for a specialist office visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Genetic Testing.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A medical deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.		
Prosthetic Devices		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
	The amount you pay is based on where the covered health care service is provided.	Prior Authorization is required.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Rehabilitation Services - Outpatient Therapy		
Limited to: 60 visits of any combination of physical therapy and occupational therapy. 36 visits of pulmonary rehabilitation therapy. 36 visits of cardiac rehabilitation therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. Limits do not apply to Therapeutic Care for Treatment of Autism Spectrum Disorder, Early Intervention Services, Chiropractic Services, Speech therapy, or pulmonary rehabilitation therapy.	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 45 days per year in a skilled nursing facility. Limited to 60 days per year in an inpatient rehab facility.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Speech and Hearing Services		
	The amount you pay is based on where the covered health care service is provided. Examples include but are not limited to the following: Benefits for speech and hearing therapy related to rehabilitation will be the same as found under Rehabilitation Services - Outpatient Therapy in this Benefit Summary. Benefits for speech and hearing services during a Physician's office visit will be the same as found under Physician's Office Services - Sickness and Injury in this Benefit Summary. Benefits for lab, x-ray and diagnostic services related to speech and hearing testing will be the same as found under Lab, X-ray and Diagnostics - Outpatient in this Benefit Summary.	

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Surgery - Outpatient		
	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Telehealth		
	The amount you pay is based on where the covered health care service is provided.	
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	10% co-insurance, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.
Transplantation Services		
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.	Prior Authorization is required.
Urgent Care Center Services		
	$50 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Vision Exams		
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.		
Limited to 1 exam every 12 months.	$15 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; adventure-based therapy, wilderness therapy, outdoor therapy or similar programs, art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in Section 1: COC.

Autism Spectrum Disorders Treatment

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Educational services that are focused on mainly building skills and capabilities in communication, social interaction and learning. This exclusion does not apply to Benefits described under Autism Spectrum Disorders Treatment in Section 1 of the COC consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions shown in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for, by the school under the Individuals with Disabilities Education Act. Transitional Living services.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all related expenses, including hospitalizations and anesthesia, except as described under Dental Anesthesia and Facility Charges in Section 1 of the COC). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate, diseases of the mouth and if injury to the tooth was a serious injury as described under Dental Services - Accident Only in Section 1 of the COC. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: removal, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Services your plan does not cover (Exclusions)

Devices, Appliances and Prosthetics

Devices used as safety items or to help performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Cranial banding. This exclusion does not apply to items needed for the medically appropriate treatment for the diagnosis of congenital defects or birth abnormalities. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses, and ultrasonic nebulizers. Devices and computers to help in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. This exclusion does not apply to assistive technology devices for children from birth to age three who are eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431. Oral appliances for snoring. Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their traits (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and used while in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year. Certain Pharmaceutical Products that have not been prescribed by a Specialist.

Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care if you are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes; shoe orthotics; shoe inserts and arch supports.

Services your plan does not cover (Exclusions)

Gender Dysphoria

Cosmetic Procedures including the following: Abdominoplasty. Blepharoplasty. Breast enlargement, including augmentation mammoplasty and breast implants. Body contouring, such as lipoplasty. Brow lift. Calf implants. Cheek, chin, and nose implants. Injection of fillers or neurotoxins. Face lift, forehead lift, or neck tightening. Facial bone remodeling for facial feminizations. Hair removal. Hair transplantation. Lip augmentation. Lip reduction. Liposuction. Mastopexy. Pectoral implants for chest masculinization. Rhinoplasty. Skin resurfacing. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple). Voice modification surgery. Voice lessons and voice therapy.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of DME or prosthetic devices for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics and Supplies and Prosthetic Devices in Section 1 of the COC. This exception does not apply to supplies for the administration of medical food products.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC

Tubing and masks except when used with DME as described under Durable Medical Equipment (DME), Orthotics and Supplies in Section 1 of the COC. Prescribed or non-prescribed publicly available devices, software applications and/or monitors that can be used for non-medical purposes. Repair or replacement of DME or orthotics due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Mental Health Care and Substance-Related and Addictive Disorders

Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to Benefits described under Autism Spectrum Disorders Treatment in Section 1 of the COC consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions shown in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act. Transitional Living services.

Nutrition

Individual and group nutritional counseling including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula and donor breast milk. This exclusion does not apply to Medical Foods for Covered Persons, for which Benefits are provided as described under Medical Foods or Mental Health Care and Substance-Related and Addictive Disorders Services in Section 1 of the COC. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes. This exclusion does not apply to Medical Foods for Covered Persons, for which Benefits are provided as described under Medical Foods or Mental Health Care and Substance-Related and Addictive Disorders Services in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot and cold compresses; hot tubs; humidifiers; jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness or flexibility. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs.

Procedures and Treatments

Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment. This does not apply to Autism Spectrum Disorder. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder. Habilitative services for maintenance/preventive treatment. This does not apply to Benefits which are provided as described under Autism Spectrum Disorder Services or Early Intervention Services in Section 1 of the COC. Outpatient cognitive rehabilitation therapy except for long term or progressive conditions such as following a post-traumatic brain Injury, cerebral vascular accident, cerebral palsy, Alzheimer's disease, Parkinson's disease or stroke. Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for you because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary tobacco cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. Helicobacter pylori (H. pylori) serologic testing.

Services your plan does not cover (Exclusions)

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal address. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider has not been involved in your medical care prior to ordering the service, or is not involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. Gestational carrier (surrogate parenting), donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. In vitro fertilization regardless of the reason for treatment.

Services Provided under Another Plan

Health care services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy. Health care services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health care services during active military duty.

Transplants

Health care services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health care services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient’s Benefits under the Policy.) Health care services for transplants involving permanent mechanical or animal organs.

Travel

Health care services provided in a foreign country, unless required as Emergency Health Care Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Care Services received from a Designated Provider may be paid back as determined by us. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care aides. Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Services your plan does not cover (Exclusions)

Vision and Hearing

Cost and fitting charge for eyeglasses and contact lenses. Implantable lenses used only to fix a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: You have craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid. You have hearing loss of sufficient severity that it would not be remedied enough by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time you are enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid when you meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

Health care services and supplies that do not meet the definition of a Covered Health Care Service. Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Care Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when: required only for school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders. (This exclusion does not apply to services that are determined to be Medically Necessary). Conducted for purposes of medical research (This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to get or maintain a license of any type. Health care services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply if you are a civilian injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health care services received after the date your coverage under the Policy ends. This applies to all health care services, even if the health care service is required to treat a medical condition that started before the date your coverage under the Policy ended. This exclusion does not apply if you are eligible for and choose continuation coverage or if you are eligible for extended coverage for Total Disability. For more information refer to Section 4 of the COC. Health care services when you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Policy. In the event an out-of-Network provider waives, does not pursue, or fails to collect co-payments, co-insurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the co-payments, co-insurance and/or deductible are waived. Charges in excess of the Allowed Amount or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider. Health care services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Care Services if the service treats complications that arise from the non-Covered Health Care Service. This exclusion does not apply to services covered under Emergency Health Care Services. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

For Internal Use only:
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Item#	**Rev. Date**	
350-8888	0318	Base/Value/Sep/Emb/35435/2018

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

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to Civil Rights Coordinator.

Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator. United HealthCare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

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

If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

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

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

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

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

We provide free services to help you communicate with us. Such as, letters in others languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

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

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

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

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

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

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

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

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

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा अपने पहचान पत्र पर दिए टाल-फ़्री फ़ोन नंबर पर काल करें।

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

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

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

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

SLPS Wellness Program

In 2009, SLPS rolled out its first wellness plan in order to help our employees either stay healthy and/or become healthy. We are so impressed with the years of success and participation and want to continue the momentum into 2019 and beyond. We will partner with UnitedHealthcare for 2019 in order to deliver a comprehensive wellness plan to our district employees.

The 2019 wellness plan will continue to include the following benefits:

1. **Digital online Missions** – services focus on losing weight, quitting smoking, exercising more, relieving stress, and more.
2. **Incentives/Rewards** – ability to earn gift cards for taking steps to understand and improve your health and well-being! See information in the box below. However, you have the right to waive participation in the gift card program.

Important Notes:

- Due to legal restrictions, UnitedHealthcare will not release any personal screening or assessment results to St. Louis Public Schools. Therefore, all personal and member-specific information is confidential.

Access the Reward Program Overview through Rally™ when you log in to myuhc.com for specific details regarding the wellness incentive program–SimplyEngaged®.

Earn a Reward:

- Participate in a biometric health screening and get a $75 reward
- Complete an online health survey through Rally when you log into myuhc.com within 90 days of the start of the program and get a $25 reward
- Get a $20 reward each month you visit a participating fitness center at least 12 times per month
- Complete a telephone-based health coaching program and get a $75 reward
- Complete at least 3 Missions through the Rally experience and get a $50 reward
- Estimate health care costs on myuhc.com and get a $25 reward

* Maximum reward per employee $200; Maximum reward per family $400. Each Employee and Spouse is eligible to receive a maximum of one reward for completing the wellness activity listed in each category. This includes a maximum of one reward per person for completing the Health Assessment.

† Children may not participate in the reward program.

UnitedHealthcare NurseLine and Care Options

With all of the options for getting care, this chart can help you understand which one is right for you and can help you save money.

Where to get care	What it is	Type of Care	Cost
NurseLine℠	NurseLine℠ connects you with registered nurses 24/7. Call 1-877-440-0547.	• Choosing appropriate medical care • Finding a doctor or hospital • Understanding treatment options • Achieving a healthier lifestyle • Answering medication questions	No Additional cost
Virtual Visit	A virtual visit lets you see a doctor via your smartphone, tablet or computer.	• Allergies • Bladder infections • Bronchitis • Cough/colds • Diarrhea • Fever • Pink eye • Rashes • Seasonal flu • Sinus problems • Sore throats • Stomach aches	No Additional Cost
Convenience Care Clinics	Visit a convenience care clinic when you can't see your doctor and your health issue isn't urgent. These clinics are often in stores.	• Common infections (e.g. strep throat) • Minor skin conditions (e.g. poison ivy) • Vaccinations • Pregnancy tests • Minor injuries • Ear aches	$$
Primary Care Physician	Go to a doctor's office when you need preventive or routine care. Your primary doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	• Checkups • Preventive services • Minor skin conditions • Vaccinations • General health management	$$
Urgent Care	Urgent care is ideal for when you need care quickly, but it is not an emergency and your doctor isn't available. Urgent care centers treat issues that aren't life threatening.	• Sprains • Strains • Small cuts that may need a few stitches • Minor burns • Minor infections • Minor broken bones	$$$
Emergency Room	The ER is for life-threatening or very serious conditions that require immediate care. This is also when to call 911.	• Heavy bleeding • Large open wounds • Sudden change in vision • Chest pain • Sudden weakness or trouble talking • Major burns • Spinal injuries • Severe head injury • Breathy difficulty • Major broken bones	$$$$

Behavioral Health & Substance Abuse

Understanding Your Needs

UnitedHealthcare provides mental health and substance abuse services through United Behavioral Health ("UBH"). UnitedHealthcare and UBH work with you to help address behavioral health issues and improve your well-being.

UBH Case Managers help you receive the treatment you need.

They provide confidential support and treatment through a network of licensed and certified professionals, covering a variety of specialties to address your emotional wellness needs.

Getting Started

If you have questions concerning your behavioral health benefits and/or you would like to request services, please call the number below. This number can also be found on your UnitedHealthcare member ID card.

Experienced UBH personnel are available around the clock, and calls are kept confidential.

UBH providers offer a wide range of services, including, but not limited to:

- inpatient care
- outpatient therapy
- medication management
- alcohol or drug dependency programs
- intensive outpatient treatment

When You Call

You are connected with an experienced Behavioral Health Specialist who helps you decide the type(s) of service you need.

UBH will:

Provide you with all the information you need to schedule an appointment.

Ensure you receive the services you need to address your behavioral health concerns.

Behavioral Health Benefits

Your behavioral health benefit provides you with support for a wide range of concerns, such as:

- Managing stress
- Depression
- Eating disorders
- Coping with grief and loss
- Alcohol or drug dependency
- Anger management
- Anxiety
- Mental disorders
- Physical abuse
- Schizophrenia
- Mood disorders
- If you suffer from a behavioral health condition, UnitedHealthcare and UBH are here to help you get the treatment you need.

Physician Referral is NOT Required. Members or Providers can contact United Behavioral Health directly for a referral:

1-800-622-7276

Employee Assistance Program

Optum Employee Assistance Program is a free confidential service that provides individuals and their families with the resources and tools to live a balanced and healthy life at home and at work. Optum EAP counselors are available 24 hours a day, seven days a week to assist you. Using one toll-free phone number, you can speak with a Masters-Level Counselor who can assist you with a wide variety of issues.

Connecting People With Information They Need

Optum EAP services connects people with reliable resources for information and support regarding a wide range of personal concerns 24 hours a day, 365 days per year.

One toll-free phone number gives you access to experienced professionals.

- Masters-Level Counselors
- Legal and Financial Professionals
- Community Resources

Expanded Support

If Face-to-Face services are appropriate for your situation, an Optum EAP counselor will refer you to a local provider who can schedule a counseling appointment for you. Counselors can also refer you to a wide range of community resources.

24-Hour Convenience

Optum EAP counselors help you and your family to identify and address concerns that span the spectrum of work and life.

How to Access your EAP

EAP services are available 24 hours a day, 7 days a week. To contact a Counselor, call 1-800-622-7276 and someone in their access center will assist you. For Online Access, go to www.liveandworkwell.com, Enter Access Code: SLPS.

Services Your EAP Offers –

- **Face-to-Face Counseling—up to 3 sessions per issue per year**
- **Marital and Family Relationships**
- **Stress Management**
- **Alcohol and Drug Issues**
- **Work-Related Concerns**
- **Depression and Anxiety**
- **Bereavement**
- **Life Coaching Services**
- **Online Services and Access**
- **Webinars**
- **Online Mental Wellness Services**
- **Legal Services**
  - **Consultation**
  - **Referrals**
- **Financial Services**
  - **Consultation**
  - **Referrals**
  - **Webinars**

Prescription Drug Benefits

The cost of prescription drugs is increasing rapidly - resulting in higher expenses for the District. Using your prescription drug benefit effectively by requesting generic drugs will help both you and the District manage expenses. The prescription drug program is self-funded by the District and currently administered by Express Scripts.

Prescription drugs are available to you for a co-payment that is dependent on the retail cost to the plan. This allows you and your physician to research the cost of various drugs that may be of benefit to you and determine the cost of the various drug options available to you.

The chart below compares your prescription drug benefits under the UnitedHealthcare Base and Buy Up plan options.

	Participants in UnitedHealthcare Choice Plus Base Plan	Participants in UnitedHealthcare Choice Plus Buy Up Plan
Prescription Drugs		
Co-pay at Participating Retail Pharmacies	$10* (drug cost of $10-$40) $25 (drug cost of $40.01-$80) $40 (drug cost of $80.01 & above)	$10* (drug cost of $10-$40) $20 (drug cost of $40.01-$80) $40 (drug cost of $80.01 & above)
Co-pay for Mail Service or selected pharmacies (up to a 90-day supply)	$20 (drug cost of $20-$80) $50 (drug cost of $80.01-$160) $80 (drug cost of $160.01 & above)	$20 (drug cost of $20-$80) $40 (drug cost of $80.01-$160) $80 (drug cost of $160.01 & above)

*If the actual cost of the drug is less than the co-pay, you pay actual cost.

Don't Forget!

The prescription drug plan will provide for a voluntary prescription drug savings program that allows members the option of replacing high cost brand drugs with over-the-counter (OTC) and generic alternatives.
The OTC program will cover over-the-counter equivalents of high cost and highly utilized drugs in the following three drug classes: PPIs (acid reducers, e.g. "Nexium"); NSAIDs (non steroidal anti-inflammatory drugs, e.g., "Celebrex"); and Antihistamines (e.g., brand drug Clarinex; OTC drug Claritin). The program will feature a zero ($0) co-pay for members able to use an OTC alternative with a physician's prescription.

Special Note:

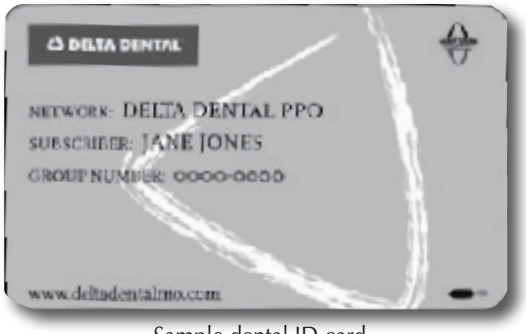
Retail 90-day supplies of maintenance medications can be filled at any in-network pharmacy location or by mail order via **www.express-scripts.com**. Click on "members"and register on the website. Once registered, follow the instructions to request prescriptions by mail.

The National Pharmacy network contains over 50,000 pharmacies which contain both chain pharmacies and independent pharmacies.

Examples of in-network Chain Pharmacies: Medicine Shoppe, Schnucks, Walgreen's, Wal-Mart, Target and K-Mart.

Pharmacy Locator services are available by contacting customer service at **1-877-850-3340** or by logging onto **www.express-scripts.com**. Once you have logged in, click "My Prescription Plan" and then click "Locate Pharmacy."

Dental Plan



Sample dental ID card

Delta Dental coverage helps you and your family with the cost of maintaining good dental health and treating dental disease or injury.

Your personal enrollment worksheet lists the options available to you, along with each option's cost per pay period.

	PPO	Premier	Out of Network
Deductible		Waived for Preventative & Ortho	
• Individual	$0	$100	$100
• Family	$0	$300	$300
Coinsurance			
• Preventative	100%	90%	70%
• Basic	80%	60%	50%
• Major	50%	40%	20%
Periodontics Covered Under		Basic	
Endodontics Covered Under		Basic	
Oral Surgery Covered Under		Basic	
Annual Maximum	$2,500	$1,500	$1,000
Orthodontia	50% to $1,000	50% to $1,000	50% to $1,000
Waiting Periods		None for Timely Entrants	
Out of Network UCR		Maximum Plan Allowance	
Dependent Age Limit		26	

PPO Network Dentists	Accept lower fee allowances and do not bill the patient for amounts over the PPO fee allowance - your out-of-pocket costs may be less.
	Will not bill patients for certain services that are considered a component of a standard procedure- saving you money.
	Under contract to file claims for Delta Dental patients - saving you time.
	Will only charge for deductibles, coinsurance and any non-covered services.
	Benefit payments are made directly to PPO network dentists.

Premier Network Dentists	Accept the Premier network contracted allowance and do not bill the patient for amounts over the contracted allowance - your out-of-pocket costs may be less.
	Will not bill patients for certain services that are considered a component of a standard procedure- saving you money.
	Under contract to file claims for Delta Dental patients- saving you time.
	Will only charge for deductibles, coinsurance and any non-covered services.
	Benefit payments are made directly to Premier network dentists.

Dentists not in a Delta Dental Network	Are reimbursed up to the allowed amount of what dentists charge in the same geographic area and with the same specialty.
	Bill the patient for ALL amounts not covered by the plan.
	Are not under contract to file claims for the patient.
	Benefit payments for non-network dentists are made to the member.

Vision Plan

The Vision Plan provides coverage for basic vision care services for you, and if applicable, your eligible family members. The plan is offered through Vision Benefits of America (VBA). You can search for VBA providers at **www.visionbenefits.com**.

Your personal enrollment worksheet lists your vision options and associated costs per pay period.

Buy-Up Plan	In-Network Provider	Out-of-Network Provider	
	You Pay	***You Pay***	***Plan will reimburse up to****
Examination	$10	100%	$36
• Lenses	$10		
• Single Vision		100%	$28
• Bifocal		100%	$45
• Trifocal		100%	$56
• Lenticular		100%	$80
• Polycarbonate (under age 19)		100%	$0
• Tinted (pink #1 or #2 only)		100%	$0
Frames	$10	100%	$45
Contact Lenses (evaluation and fitting)			
• Medically Necessary	Usual, Customary and Reasonable	100%	$210
• Elective	$130	100%	$130

* You will also pay a co-pay equal to the in-network co-pay amount.

Base Plan

Vision examinations are allowed once each 12 months.

New frames will be provided once each 24 months.

New lenses or contacts will be provided once each 24 months.

Base Plan elective contacts allowance of $105
In-Network Provider and Out-of-Network Provider.

Buy-Up Plan

Vision examinations are allowed once each 12 months.

New frames will be provided once each 12 months.

New lenses or contacts will be provided once each 12 months.

Special Note:
VBA is a voucher program. When you are ready to use this benefit, you will need to obtain a vision authorization by calling **1-800-432-4966** or by logging on to the Vision Benefits of America website at **www.visionbenefits.com**.

Providers that do not require an authorization voucher are noted on the Vision Benefits website.

Vision Plan -Board of Education City of St. Louis

VISION BENEFITS OF AMERICA (VBA) maintains a network of more than 15,000 Participating Optometrists, Ophthalmologists and Retail Locations nationwide to provide professional vision care for persons covered under this plan.

What are the benefits?

VISION EXAMINATION - A complete analysis of the eyes and related structures to determine the presence of any vision problems.

- SPECTACLE LENSES-Your program provides the finest quality lenses fabricated to VBA's exacting standards. A VBA Participating Provider will order the proper lenses and verify their accuracy when finished.
- FRAMES-VBA plans offer a wide selection of fully covered designer frames; however, if you choose a frame which costs more than the amount allowed by your plan, you will be responsible for any additional controlled charges.

-or-

- CONTACTS SELECTED IN LIEU OF GLASSES-When contact lenses are selected in lieu of glasses, your plan will provide a total allowance of up to $130.00 toward their cost. THIS IS IN LIEU OF ALL OTHER BENEFITS FOR THE BENEFIT PERIOD. YOU WILL NOT RECEIVE ANY ADDITIONAL MONIES FOR CONTACT LENSES AND/OR CONTACT LENS EXAM COSTS THAT ARE MORE THAN THE $130.00 ALLOWANCE.

MEDICALLY NECESSARY CONTACT LENSES-Contact lenses are fully covered on a UCR* basis when a VBA Participating Provider receives prior approval for one of the following services related to eye disease or injury:

a) Following cataract surgery
b) To correct extreme visual acuity problems not correctable with spectacle lenses
c) To correct for significant anisometropia
d) To correct for keratoconus

- LASIK - All VBA covered subscribers are eligible to receive a significant discount at hundreds of provider locations nationwide. For more information regarding this benefit, please call VBA's Customer Service at 1-800-432-4966/option 5.
- Usual, Customary, Reasonable as determined by VBA.

*See Extra Cost and Non-Covered items as outlined in Section VI.

How often are these services available? (from the last date of service)

EXAMINATION: Once every 12 months
LENSES: Once every 12 months
FRAMES: Once every 12 months
-or-
CONTACT LENSES (in lieu of all other benefits for the benefit period): Once every 12 months

How much do I pay?

When you choose to obtain services from a VBA Participating Provider, this plan covers the benefits described herein (examination, professional services, lenses and frames) at no expense to you, if the materials selected fall within your plan's allowance. A $10 copayment applies to the vision exam and a $10 copayment applies to the total cost of the lenses and/or frames selected through a VBA Participating Provider only. The copayment (s) do not apply to the contacts.

How do I use this plan?

Prior to receiving vision benefits, you can easily check your eligibility and find a VBA Provider near your area by doing one of the following:

- Call VBA at 1-800-432-4966/push "1" then "5" and a VBA service representative will answer all of your questions, including helping you find a provider who would accept VBA's paperless E-Claims system - where you do not need a paper benefit form.

-or-

- Visit VBA's website at www.visionbenefits.com and obtain the same information, including providers with their names emboldened if they accept VBA's E-Claims system. When making your paperless claims appointment, please let the office know that you would like to use the VBA E-Claims system.

-or-

- If you prefer to use VBA's paper benefit form, simply call the same number, or visit the same website, and follow the instructions to request the VBA benefit form, which will be mailed directly to your home, along with a printed list of all VBA providers in your area.

Option I

If You Select the VBA Benefit Form and use a VBA Participating Doctor:

1. Choose a VBA Participating Doctor from the printed roster and make an appointment for the eye examination.
2. You MUST present the benefit form to the VBA Participating Doctor on your first visit. Failure to do so will result in your being partially reimbursed according to the Non-Participating Provider Reimbursement Schedule. When the examination has been completed, the VBA Participating Doctor will have you sign the benefit form and pay the copayment(s), if applicable.
3. The VBA Participating Doctor will take care of all paperwork for payment. VBA will pay the Doctor for the services you received according to VBA's contractual agreement with the Doctor.

Option II

If You Choose to See an Optometrist, Ophthalmologist or Dispensing Optician Who Is Not A VBA Participating Provider:

1. Make an appointment and receive the necessary services from the provider. Pay the Provider his full fee and obtain an itemized receipt which must contain the following information:

Vision Plan -Board of Education City of St. Louis

a) Patient's name
b) Date services began
c) The services and/or materials the patient received
d) The type of lenses the patient received (single vision, bifocal, etc.)

2. Mail your VBA Benefit Form and itemized receipts to:
   VISION BENEFITS OF AMERICA
   300 Weyman Plaza, Suite 400
   Pittsburgh, PA 15236-1588
3. You will be reimbursed directly according to the following Reimbursement Schedule:

Non-participating provider reimbursement schedule

PROFESSIONAL FEES	
Vision Examination, up to	$ 36.00
OPHTHALMIC MATERIALS	(pair)
Single Vision Lenses, up to	$ 28.00
Bifocal Lenses, up to	45.00
Trifocal Lenses, up to	56.00
Lenticular Lenses, up to	80.00
One Year Scratch Protection	N/A
Polycarbonate Lens Material	N/A
Frames, up to	$ 45.00

-or-

CONTACT LENSES (In lieu of all other benefits for the benefit period. You will not receive any additional monies for contact lenses and/or contact lens exam costs that are over the allowance).

Elective (In Lieu of Glasses)	$ 130.00
Medically Necessary	210.00

THERE IS NO ASSURANCE THE NON-PARTICIPATING PROVIDER REIMBURSEMENT SCHEDULE WILL COVER THE ENTIRE COST OF THE EXAMINATION, GLASSES OR CONTACTS.

Option III

If You Choose to See A Non-Participating Provider For An Eye Exam and Have A VBA Participating Provider Fill Your Prescription:

1. After receiving an eye exam from the Doctor, pay the Doctor his exam fee. Obtain a receipt for the exam and the prescription for your lenses.
2. Call one of the VBA Participating Providers who has an asterisk beside their name (this means they are willing to fill another Doctor's prescription) and make an appointment to have your prescription filled/lenses made.
3. Take your VBA Benefit Form and your prescription to the VBA Participating Provider on your first visit. They will fit you with your new glasses and take care of any paperwork associated with the glasses. The Participating Provider will be paid by VBA for all covered services.
4. You will be paid directly for your eye exam according to the above Reimbursement Schedule. Simply submit the paid exam receipt to VBA and indicate your employer's name and the employee's ss#.

NOTE: If any problems arise with your glasses or contacts due to an inaccurate prescription written by a Non-Participating Provider, VBA and our Participating Provider assume no responsibility.

Who is eligible?

The employee, as well as his or her dependents (if dependent coverage is provided). Eligible dependents would include the spouse and dependent children. Please check with your employer for age limits.

What optional vision materials are available at controlled pricing under this plan?

EXTRA COST--This plan is designed to fully cover your visual needs rather than cosmetic lens & frame options. There will be controlled extra costs involved if you select any of the following:

a) Rimless frames
b) A frame that costs more than your plan's allowance
c) Elective contact lenses (in excess of your plan's allowance)
d) Progressive lenses (available starting at $45.00)
e) Polycarbonate lens material for adults (covered if under 19)
f) Photosensitive lenses (glass or plastic)
g) Tinted lenses
h) Coated lenses (except 1 yr scratch protection is included)

NOT COVERED ITEMS--There are no benefits for professional services or materials connected with:

a) Orthoptics or vision training, subnormal vision aids or non-prescription lenses.
b) Lenses and frames furnished under this program which are lost or broken. These will not be replaced unless you are eligible for frames or lenses at that time.
c) Medical or surgical treatment of the eyes.
d) Two pairs of glasses in lieu of bifocals.
e) Services or materials provided as a result of any Workers' Compensation Law or similar legislation.
f) Any eye examination required by an employer as a condition of employment; or any services or materials provided by any other vision care plan, or group benefit plan containing benefits for vision care.

IF YOU HAVE QUESTIONS ABOUT YOUR VISION CARE COVERAGE OR THE FILING OF YOUR CLAIM, PLEASE CONTACT THE CUSTOMER SERVICE DEPARTMENT AT 1-800-432-4966.

VBA#670 09/12

Basic & Supplemental Life Benefits

- Additional Services available to St. Louis Public School Employees are: Will and Trust Preparation Services and Beneficiary Services. Information on both of these benefits is located on pages 87 and 88.
- Company Paid Basic Life and Accidental Death and Dismemberment (AD&D)
- Voluntary Employee Supplemental Life, Supplemental Dependent Spouse and Child Life Plan

Employee Basic Life	Eligibility	All Active Full-Time Employees (excludes Superintendents)
	Life and AD&D Benefit	$40,000
	Guarantee Issue	$40,000
Eligibility - Supplemental Life Employee and Dependent		All Active Full-Time Employees
Employee Supplemental Life	Life Benefit	$5,000; $10,000; $20,000; $50,000; $75,000; $100,000; $125,000; $150,000; or $200,000
	Guarantee Issue	$200,000
Employee Coverage Provisions	Benefit Reduction	No age reductions Coverage ceases at retirement
	Accelerated Death Benefit	Up to 75% of life benefit not to exceed $200,000 is payable if life expectancy is 12 months or less
	Waiver of Premium	To age 65 if disabled prior to age 60 and the disability lasts at least 6 months
	Portability	The lesser of the Employee's combined in force Basic and Supplemental life amounts or $240,000
Dependent Supplemental Life	Spouse Life Benefit	$10,000 to $100,000 in increments of $10,000 not to exceed 50% of employee's supplemental life amount (Example: If employee elects $20,000, the Spouse cannot elect more than $10,000)
	Child Life Benefit (14 days of age to age 26)	$5,000; $7,500; or $10,000
	Guarantee Issue	Spouse: $20,000 Child(ren): $10,000
	Portability	The lesser of the Dependent's in force supplemental life amount or $100,000

- Limitations for AD&D: Disease, bodily or mental infirmity, suicide or intentionally self-inflicted injury, commission of an assault or felony, war, use of any drug unless prescribed by physician, driving while intoxicated, engaging in any hazardous activities, or travel in a private aircraft.
- This is a summary of benefits only and does not include all plan provisions, exclusions, and limitations relating to your coverage. Please refer to your Certificate of Coverage. If differences exist between this summary and your Certificate of Coverage, the Certificate of Coverage will govern.
- Late applicants are subject to Evidence of Insurability.

This is an overview of your benefits. The contract will govern actual benefits. The Company reserves the right to make future changes.

Supplemental Life Benefit

You may enhance your District-provided Basic Group Term Life Insurance by electing Supplemental Life Insurance. This coverage provides an additional benefit to your beneficiary(ies) if you die while insured. Your personal enrollment worksheet lists the options available to you, along with each option's cost per pay period. You pay the cost of this benefit on an after-tax basis.

Premium Calculation Examples:

Supplemental Life

- Employee, age 36: $200,000 x $0.32 = $64,000 / $1,000 = $64 per month
- Spouse, age 33: $20,000 x $0.32 = $6,400 / $1,000 = $6.40 per month
- Child(ren): $10,000 x $0.15 = $1,500 / $1,000 = $1.50 per month

(**Note:** monthly premium is the same regardless of the number of dependent children covered)

Your Cost at a Glance

Employee Basic Life and AD&D	100% Company Paid
Supplemental Life	$0.32 per $1,000
Employee and Spouse (requires 20% participation)	
Supplemental Child Life	$0.15 per $1,000

Depending on your situation, you may be required to provide Evidence of Insurability (EOI) when you enroll for Supplemental Life Insurance coverage, according to the following rules:

- If you are a newly hired employee, you may elect any coverage level listed on page 92 without providing EOI.
- Current employees enrolling for the first time must show EOI when selecting any level of coverage.
- Current employees who previously enrolled for coverage may increase their coverage by one level -for example, elect to increase from $10,000 to $20,000 - without providing EOI. However, EOI will be required for all increases of more than one coverage level.
- If you experience a qualified life event or change in status, you may make changes to your Supplemental Life Insurance coverage that are consistent with and on account of your change in status. If you are enrolling for the first time, you may elect coverage of $5,000 without providing EOI. You must show EOI when selecting any other level of coverage for the first time. If you are already enrolled for coverage, you may increase your coverage by one level without providing EOI. However, EOI will be required for all increases of more than one coverage level.

If your Supplemental Life Insurance selection requires you to provide EOI, you will receive a a pop-up during online enrollment, if you enroll by phone the required forms will be mailed to you. You will need to complete and return this form to: St. Louis Public Schools, Human Resources, 801 North 11th Street, St. Louis, MO 63101, Attn: Karen Shelton-Henry—Benefits/EOI enclosed. If your coverage selection is approved, your coverage will be effective the first of the month following approval and the appropriate payroll deductions will be taken.

CIGNA's Will Preparation Program

CIGNA makes it easy for you to take charge of those difficult life and health legal decisions. There are no more reasons to hesitate planning for the future with our online will preparation services. Available to individuals who have CIGNA's Group life, accident, or disability coverage.

Think you don't need a will or living will?

If you're like most people, you don't like thinking about planning for your death. However, there are many good reasons why it's very important to have a will no matter what your personal circumstances might be. For example, to have a say in your healthcare treatment if you're not able to speak for yourself, to assign guardianship for minor children, and to secure your assets.

Think you don't have enough assets to need a will?

Nearly one in four (24%) of American adults say their biggest reason for not having a will is a lack of sufficient assets.[1] Not having a will puts your family in the position of having to guess about how to manage your personal and financial assets after your death.

Think you can't afford to create a will?

Now you can! CIGNA's Will Center allows you to easily complete essential life and health legal documents online at no cost to you.

Not sure how to develop your will?

Don't worry. CIGNA's Will Center is secure, easy to use, and available to you and your covered spouse seven days a week, 365 days a year. And, if you have any questions, phone representatives are available to assist you via a toll-free number.[2] Once registered on the site, you will have direct access to a Personal Estate Planning web page, where you can:

- create and maintain your personalized legal documents
- follow an intuitive, interactive, question-and-answer process to create state-specific legal documents tailored to your situation
- preview, edit, download and print your legal documents for execution

It's easy! Go to CIGNAWillCenter.com

To access your Personal Estate Planning web page, simply complete the online form and register as a new user. When prompted for a registration code, provide your date of birth plus the last four digits of your Social Security number. Once this is completed you can immediately start building your will and other legal documents.

Now is the time to get started.

Visit CIGNAWillCenter.com to create your own personalized:

Last Will & Testament – specifies what is to be done with your property when you die, names the executor of your estate and allows you to name a guardian for your minor children.

Living Will – contains your wishes regarding the use of extraordinary life support or other life-sustaining medical treatment.

Healthcare Power of Attorney – allows you to grant someone permission to make medical decisions if you are unable to make them yourself.

Financial Power of Attorney – allows you to grant someone permission to make financial decisions on your behalf if you are unable to make them yourself.

Medical Authorization for Minors – allows you or a guardian to provide authorization for medical personnel to treat your child in the event you are not present.

Plus, find information on:

- **Estate Planning**
- **Identity Theft Information Kit**
- **CIGNA's Life and Disability Planning Kits** – access insurance calculators to determine whether you and your family have sufficient coverage for the future.

1 National Association of Estate Planners and Councils. "Wills 101: Everything You Know But Don't Want to Think About." June 2006.

2 No legal advice is provided.

Flexible Spending Accounts

Under the Flexible Spending Account (FSA) Plan, you may elect to set aside pre-tax dollars to pay for certain benefits expenses, Healthcare Reimbursement (Healthcare FSA) and/or Dependent Care Reimbursement (Dependent Care FSA). This Plan helps you because the benefits expenses you elect are nontaxable, which means that:

- Pre-tax contributions are withheld from your gross income before any applicable federal, state and local taxes have been deducted and
- You save Social Security and income taxes on the amount of your salary that you contribute to the plan. As a participant in the FSA Plan, pre-tax contributions are deducted from each paycheck (24 deductions for 12-month employees and 20 deductions for non 12-month employees) for the upcoming plan year. These deductions will appear as a credit to your FSA. As you incur eligible expenses, you will submit a claim form to be reimbursed from your account.

Healthcare FSA

The Healthcare FSA is a way for you to pay with tax-free dollars for many of your health-related out-of-pocket expenses that are not covered or fully reimbursable under your medical plan. Examples of expenses for which you may be reimbursed are those that are incurred for physician office visit co-pays, prescription co-pays, vision care expenses and even certain Over-the-Counter (OTC) drugs and medicine.

However, federal regulations do not allow any insurance premiums, warranties, service contracts, or long-term care expenses to be reimbursed under this plan.

***Certain OTC drugs and medicines will no longer be eligible for reimbursement without a prescription or Letter of Medical Need from your physician. Be sure to visit https://portal.adp.com for regular updates about OTC eligibility.**

Examples of Eligible Healthcare Expenses

- Medical plan deductibles
- Most co-payments
- Prescription drugs
- Over-the-counter (OTC) drugs and medicines purchased to alleviate or treat personal injuries or sicknesses*
- Routine checkups and physicals
- Dental and orthodontia expenses
- Vision care expenses, including exams, glasses, and contact lenses
- Laser eye surgery
- Many treatments for alcoholism or drug addiction
- Weight loss programs prescribed to treat an existing disease
- Smoking cessation programs and prescriptions prescribed by a physician
- Psychology and Psychoanalysis medical expense amounts
- Medically necessary cosmetic surgery
- Hearing Aids/batteries
- Birth control pills, devices and procedures
- Sterilization & Vasectomy
- Well baby care and immunizations
- Occupational/Physical therapy
- Chiropractor expenses for medical care
- Infertility treatments
- Massage therapy used to treat injury or trauma
- Acupuncture or related procedures when treating a medical condition

You may choose any annual Healthcare Reimbursement amount you desire, subject to the following minimum and maximum annual amounts

Payroll Schedule	Annual Minimum	Minimum Per Pay Period	Annual Maximum	Maximum Per Pay Period
12-Month	$240	$10.00	$2,000	$83.33
Non-12-Month	$240	$12.00	$2,000	$100.00

Eligible medical expenses must be incurred during the Plan Year (or the 2½ month Grace Period thereafter) and while you are a participant. You may not be reimbursed for any expenses arising before the Healthcare FSA becomes effective or for any expenses incurred after the close of the Grace Period or after a separation from employment.

If you do not incur an amount of eligible medical expenses that match the pre-tax dollars set aside and allocated to your account, the allocated amount is forfeited.

If you are a newly eligible or newly enrolled participant in the Flexible Spending Account Plans, your annual amount will be divided by the number of remaining pay periods for the calendar/plan year.

Flexible Spending Accounts

Dependent Care FSA

The Dependent Care FSA allows you to pay for qualifying dependent care expenses with tax-free dollars for eligible reimbursable dependent care expenses. Qualifying dependent care expenses are those expenses that you incur in order for you and your spouse to work or look for work during your period of coverage.

Dependent care expenses are limited to:

- Care for dependent children under age 13, who have the same principal place of abode as you and who do not provide over half of their own support, or
- A spouse or a dependent who is physically or mentally incapable of caring for himself or herself, for whom the Participant provides over one-half of the individual's support for year, and whose gross income is less than the federal tax exemption amount (currently $3,200).

Note: There is a special rule for children of divorced parents. Dependent care expenses are limited to those of the parent with whom the child resides with the longest during the year.

You'll need to get the taxpayer identification number from the facility providing care for your dependent. If an individual provides care for your dependent, a Social Security number is acceptable. The individual must report the income in order for you to get the tax advantage of using the dependent care reimbursement account.

Ineligible dependent care expenses include:

- Expenses claimed as deductions or credits on your federal income tax return
- Expenses for food, clothes, or transportation
- Expenses for the education of a dependent in the first or higher grade level
- Expenses for the care of your physically or mentally incapacitated spouse or dependent who doesn't spend at least eight hours each day in your home
- Expenses for care provided by a family member if that person is claimed as a dependent on your income tax form or under age 19

You may choose any annual Dependent Care Reimbursement amount you desire, subject to the following minimum annual amounts:

Payroll Schedule	Annual Minimum	Minimum Per Pay Period
12-Month	$240	$10.00
Non-12-Month	$240	$12.00

The annual maximum amount cannot exceed the maximum Dependent Care Reimbursement amount specified in Section 129 of the Internal Revenue Code. The maximum annual amount is currently $5,000 per Plan Year if you - (a) are married and file a joint return; (b) are married but your spouse maintains a separate residence for the last six months of the calendar year, you file a separate tax return, and you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the Dependent Care FSA; or (c) are single. If you are married and reside together, but file a separate federal income tax return, the maximum Dependent Care Reimbursement that you may elect is $2,500. In addition, the amount of reimbursement that you receive cannot exceed the lesser of the earned income (as defined in Code Section 32) of you or your spouse. For purposes of (a) above, your spouse will be deemed to have Earned Income of $250 ($500 if you have two or more Qualifying Individuals), for each month in which your spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student (as defined by Code Section 21).

Eligible dependent care expenses must be incurred during the Plan Year and while you are a participant. You may not be reimbursed for any expenses arising before the Dependent Care FSA becomes effective or for any expenses incurred after the close of the Plan Year or after a separation from employment.

If you do not incur an amount of eligible dependent care expenses that match the pre-tax dollars set side and allocated to your account, the allocated amount is forfeited.

Example of Tax Savings with Flexible Spending Accounts (FSA):

	Without FSA	With FSA
Gross Monthly Pay	$2,500	$2,500
Pre-Tax Healthcare FSA	-0-	$50
Pre-Tax Dependent Care FSA	-0-	$60
Taxable Income	$2,500	$2,390
Withholdings @22.65% (Income Tax & FICA)	($566)	($541)
After-Tax Health Care Expenses	($50)	-0-
After-Tax Dependent Care Expenses	($60)	-0-
Net Annual Salary	$1,823	$1,849
Monthly Savings of $26		

https://myspendingaccount.wageworks.com

2019 Cost of Coverage

The District pays the cost for your coverage (employee only) in the Medical, Dental and Vision Plans. You pay the full cost for your spouse and dependent children on a pre-tax basis. All elections for dependent Medical, Dental and Vision coverage are made on a pre-tax basis by way of salary deductions. An employee may choose to opt out of medical coverage if the employee has coverage under another plan and will receive a monthly credit from the District. You pay the cost for your Supplemental Life Insurance on an after-tax basis. These elections are provided under the Premium Conversion Plan maintained by the Board of Education and are governed by Internal Revenue Code Section 125.

2019 Employee Benefits Plan Year

	Monthly Premium	12-Month Employee 24 Pay Period Deductions	10, 10.5, 11-Month Employee 20 Pay Period Deductions
UnitedHealthcare Choice Plus Base Plan ($1,500 Deductible)			
Employee Only	**$701.61 (Paid by SLPS)**	**$350.81 (Paid by SLPS)**	**$420.97 (Paid by SLPS)**
Spouse	**$596.37**	**$298.19**	**$357.82**
Child(ren)	**$343.79**	**$171.90**	**$206.27**
Spouse & Child(ren)	**$797.54**	**$398.77**	**$478.52**
UnitedHealthcare Choice Plus Buy-Up 1 Plan* ($500 Deductible)			
Paid by SLPS (Same as Base)	**$701.61 (Paid by SLPS)**	**$350.81 (Paid by SLPS)**	**$420.97 (Paid by SLPS)**
Employee Only	**$41.64**	**$20.82**	**$24.98**
Spouse	**$673.40**	**$336.70**	**$404.04**
Child(ren)	**$405.83**	**$202.92**	**$243.50**
Spouse & Child(ren)	**$886.23**	**$443.12**	**$531.74**
UnitedHealthcare Choice Plus Buy-Up 2 Plan* ($200 Deductible)			
Paid by SLPS (Same as Base)	**$701.61 (Paid by SLPS)**	**$350.81 (Paid by SLPS)**	**$420.97 (Paid by SLPS)**
Employee Only	**$128.36**	**$64.18**	**$77.02**
Spouse	**$833.84**	**$416.92**	**$500.30**
Child(ren)	**$535.04**	**$267.52**	**$321.02**
Spouse & Child(ren)	**$1,070.95**	**$535.48**	**$642.57**
Delta Dental			
Employee Only	**$26.38 (Paid by SLPS)**	**$13.19 (Paid by SLPS)**	**$15.83 (Paid by SLPS)**
Spouse	$27.67	$13.84	$16.60
Child(ren)	$40.80	$20.40	$24.48
Spouse & Child(ren)	$64.33	$32.17	$38.60
Vision Benefits of America Base Plan			
Employee Only	**$1.55 (Paid by SLPS)**	**$0.78 (Paid by SLPS)**	**$0.93 (Paid by SLPS)**
Employee + 1	$2.35	$1.18	$1.41
Employee + 2 or more	$4.00	$2.00	$2.40
Vision Benefits of America Buy-Up Plan (mandatory 3 year enrollment)**			
	$1.55 (Paid by SLPS)	**$0.78 (Paid by SLPS)**	**$0.93 (Paid by SLPS)**
Employee Only	$2.45	$1.23	$1.47
Employee + 1	$8.20	$4.10	$4.92
Employee + 2 or more	$12.30	$6.15	$7.38

*** District will pay the same amount toward the Buy-Up Plans as they pay for the Base Plan. Employee will pay the difference between the Base and Buy-Up plan amount selected.**

**** District will pay the Base plan amount for employee only. The cost for the Vision Buy-Up plan represents the additional costs only.**

2019 Cost of Coverage

	Monthly Premium	12-Month Employee 24 Pay Period Deductions	10,10.5, 11-Month Employee 20 Pay Period Deductions
CIGNA Insurance (BASIC and AD&D)			
$40,000 Basic Life $40,000 AD&D	($7.20) Paid by SLPS ($.60) Paid by SLPS	($3.60) Paid by SLPS ($.30) Paid by SLPS	($4.32) Paid by SLPS ($.36) Paid by SLPS
CIGNA Supplemental Life EMPLOYEE			
$5,000	$1.60	$0.80	$0.96
$10,000	$3.20	$1.60	$1.92
$20,000	$6.40	$3.20	$3.84
$50,000	$16.00	$8.00	$9.60
$75,000	$24.00	$12.00	$14.40
$100,000	$32.00	$16.00	$19.20
$125,000	$40.00	$20.00	$24.00
$150,000	$48.00	$24.00	$28.80
$200,000	$64.00	$32.00	$38.40
CIGNA Supplemental Life SPOUSE			
$10,000	$3.20	$1.60	$1.92
$20,000	$6.40	$3.20	$3.84
$30,000	$9.60	$4.80	$5.76
$40,000	$12.80	$6.40	$7.68
$50,000	$16.00	$8.00	$9.60
$60,000	$19.20	$9.60	$11.52
$70,000	$22.40	$11.20	$13.44
$80,000	$25.60	$12.80	$15.36
$90,000	$28.80	$14.40	$17.28
$100,000	$32.00	$16.00	$19.20
CIGNA Supplemental Life DEPENDENT CHILD			
$5,000	$0.75	$0.38	$0.45
$7,500	$1.13	$0.56	$0.68
$10,000	$1.50	$0.75	$0.90

Notice: Medicare Part D Certificate of Creditable Coverage

Important Notice from the Board of Education of the City of St. Louis About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Board of Education about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare Drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare 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. **The Board of Education of the City of St. Louis has determined that the prescription drug coverage offered by Express Scripts is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Express Scripts coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current coverage offered by Board of Education of The City of St. Louis, be aware that you and your dependents may be able to get this coverage back, as long as you are an eligible active full time employee.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your coverage with The Board of Education of the City of St. Louis and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information: Human Resources Reception at 314-231-3720 for assistance with Medicare Prescription Drug Coverage information ONLY.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Board of Education of The City of St. Louis changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Employee Notices

continued from page 120...

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**,
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: 10/1/2018
Name of Entity/Sender: Board of Education of The City of St. Louis
Contact-Position/Office: Human Resources Reception for Medicare Prescription Drug Coverage ONLY
Address: 801 North 11th Street, St. Louis, MO 63101
Phone Number: (314) 231-3720

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Notice: HIPAA Special Enrollment Rights

If you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
To request special enrollment or obtain more information, contact the Benefits Call Center at 1-866-345-7577.

Notice: Women's Health & Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator.

Notice: 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 eligible for health 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 already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

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.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, 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 toll-free 1-866-444-EBSA (3272).

See the next two pages for more CHIP information.

Employee Notices

CHIP continued...

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2018. You should contact your State for further information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/State Relay 711
FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid
Website: http://chfs.ky.gov Phone: 1-800-635-2570
LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999

Employee Notices

CHIP continued...

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2018 or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/2019)



Contact Information

Benefits Call Center
1-866-345-7577
https://portal.adp.com

MEDICAL
UnitedHealthcare
1-844-298-8930
www.myuhc.com

PRESCRIPTION DRUGS
Express Scripts
1-877-850-3348
www.express-scripts.com

DENTAL
Delta Dental
1-800-335-8266
www.deltadentalmo.com

VISION
Vision Benefits of America
1-800-432-4966
www.visionbenefits.com

LIFE INSURANCE
Cigna
1-800-732-1603

FLEXIBLE SPENDING ACCOUNTS
https://myspendingaccount.wageworks.com

Employees can make changes online at **https://portal.adp.com** by selecting the link "Enroll in 2019 Benefits."
Employees may also contact the Benefits Call Center at 1-866-345-SLPS (7577).

Customer Service Representatives are available on a year-round basis, Mon - Fri, 8 a.m. - 6 p.m. CST.

SAINT LOUIS PUBLIC SCHOOLS

Enroll Online at **https://portal.adp.com**

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.