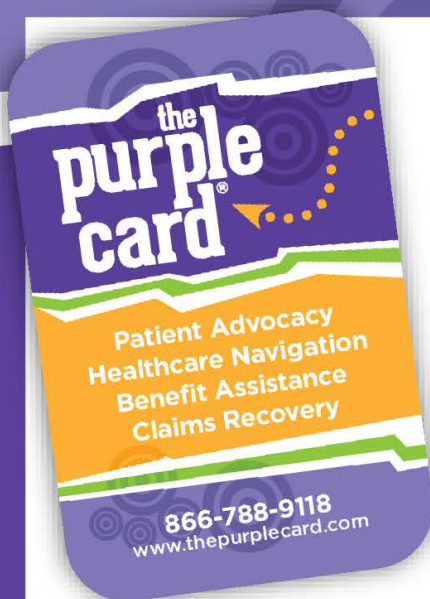




Talentcare

2025
Open Enrollment Guide



We are pleased to announce the Patient Advocate service provided by Brinson Benefits. **The Purple Card®** is a Patient Advocate service which allows you direct access to the Brinson Benefits office for assistance with your employee benefits.

At Brinson Benefits, our job is to ensure that you are completely satisfied with your employee benefit plans. Please contact **The Purple Card®** with all of your benefit questions or concerns.

The **Purple Card®** provides the following types of assistance:

purple card assistance	expected timeline
emergency • You've lost your ID card and the provider's office needs to verify benefits •	immediately - 24 hours
enrollment support & eligibility • You have questions about benefit information discussed at Open Enrollment meetings • Your dependent is losing coverage and needs to enroll in your plan •	immediately - 48 hours
benefit assistance & coverage • You need help filling a prescription at the pharmacy or a carrier drug program • You need to verify coverage for a particular medical procedure or service •	24 - 48 hours
physician & provider search • You need assistance locating a physician or provider in your area •	immediately - 24 hours
claims & quality care • You have a question about how a claim was processed or you're being balance-billed by your provider • You have a quality of care question and need to know if you are receiving the right care for your medical condition •	2 days - 1 week
complex claims • You had a procedure done in which you're receiving multiple bills and you do not understand what your financial responsibilities are for each bill •	1 - 4 weeks

Just Pull Out Your Purple Card and Call

866.788.9118

8:30am – 5:30pm | Monday – Friday





About Your Open Enrollment

Annual Benefits Open Enrollment Period

March 28th through April 4th

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

Elections you make during open enrollment will become effective on 5/1/25 and be in place until 4/30/26. We encourage you to take the time to learn more about your options and choose the best coverage for you and your family

Changes Outside of Open Enrollment

Unless you have a qualifying event, you cannot make changes to your benefits until the next open enrollment period. Any qualifying event changes must be processed and received within 30 days of the qualifying event date.

Sample Qualifying Events Include

Loss of other qualified coverage (this applies to the employee, spouse and children). Marriage, divorce or legal separation. Birth or adoption of a child. Death of a spouse, child or other qualifying dependent.

Medical Benefits

Our medical coverage continues with United HealthCare. Locate providers by calling The Purple Card at 866.788.9118.

	HE500025B HSA	HP635025B HSA
Carrier	UnitedHealthcare	UnitedHealthcare
Plan Name	HSA EPO Level Funded	HSA Level Funded
Plan Type	EPO	PPO
Network	Choice	Choice Plus
Deductible	\$5,000	\$6,350 / \$12,700
Coinsurance	100%	100% / 50%
Max Out-of-Pocket	\$5,000	\$6,350 / \$25,400
Primary Care Office Visit	100% After Ded.	100% After Ded.
Specialty Office Visit	100% After Ded.	100% After Ded.
Lab Copay	100% After Ded.	100% After Ded.
X-Ray Copay	100% After Ded.	100% After Ded.
Urgent Care	100% After Ded.	100% After Ded.
Emergency Room	100% After Ded.	100% After Ded.
RX	100% After Ded.	100% After Ded.

Semi Monthly Payroll Employee Deductions (24)

	Medical Plans	
Per Pay Period	HE500025B HSA	HP635025B HSA
Employee Only	\$128.51	\$113.84
Employee & Spouse	\$452.81	\$398.82
Employee & Child(ren)	\$363.26	\$320.13
Employee & Family	\$689.99	\$607.25

Medical Benefits

Our medical coverage continues with United HealthCare. Locate providers by calling The Purple Card at 866.788.9118.

	PROP200015i8021B	PROP400015i8022B
Carrier	UnitedHealthcare	UnitedHealthcare
Plan Name	PROFormance PPO Level Funded	PROFormance PPO Level Funded
Plan Type	PPO	PPO
Network	Choice	Choice
Deductible	\$2,000 / \$5,000	\$4,000 / \$7,500
Coinsurance	80% / 50%	80% / 50%
Max Out-of-Pocket	\$8,150 / \$10,000	\$8,150 / \$15,000
Primary Care Office Visit	\$15 Copay	\$15 Copay
Specialty Office Visit	Des. NW: \$50 Copay; Network: \$100 Copay	Des. NW: \$50 Copay; Network: \$100 Copay
Lab Copay	80% After Ded.	80% After Ded.
X-Ray Copay	80% After Ded.	80% After Ded.
Urgent Care	\$25 Copay	\$25 Copay
Emergency Room	\$300 Per Occurrence Copay + 80% After Ded.	\$300 Per Occurrence Copay + 80% After Ded.
RX	10T1/35T2/75T3/250T4	10T1/35T2/75T3/250T4

Semi Monthly Payroll Employee Deductions (24)

	Medical Plans	
Per Pay Period	PROP200015i8021B	PROP400015i8022B
Employee Only	\$142.41	\$130.48
Employee & Spouse	\$503.97	\$460.07
Employee & Child(ren)	\$404.13	\$369.07
Employee & Family	\$768.40	\$701.12



Health Savings Account (HSA)

If you participate in the High-Deductible Health Plan, you can set aside money in a Health Savings Account (HSA). An HSA is a type of personal savings account you can set up to pay certain health care costs. An HSA allows you to put money away and withdraw it tax-free, as long as you use it for qualified medical expenses, like deductibles, copayments, coinsurance, and more. You're eligible to contribute to an HSA when you're covered by certain high-deductible health plans (HDHPs).

Benefits of Health Savings Accounts

No Federal Income Tax

You aren't taxed on money you put into it, or on interest earned, in an HSA account. You also don't pay tax on withdrawals for qualified medical expenses.

No expiration date on funds.

Contributions Don't Expire

The money stays in the HSA until you use it.

Use for Spouse and Dependents

In many instances, you can use your HSA to pay for qualified medical expenses for your spouse and dependents, even if your high-deductible health plan doesn't cover them

Dental Benefits

DENTAL PLAN

Dental coverage is key to your overall health and we offer dental benefits through Humana. For an in-network provider call the Purple Card at 866.788.9118 to speak with an advocate.

Carrier	Humana
Plan Type	PPO TX Trad+ O1K U&C 100/80/50
Deductible	\$50
Maximum Allowable Benefit	
Annual Maximum	\$1,500
Benefits	
Preventive Care	100%
Basic Care	80%
Major Care	50%
Child Orthodontics	50%

Vision Benefits

VISION PLAN

Your vision benefit will be also be with Humana. For an in-network provider call the Purple Card at 866.788.9118 to speak with an advocate.

Network	Humana
Copays	
Examination	\$10 copay / Up to \$30 reimbursement
Materials	
Lenses	Single: \$15 copay / up to \$25 reimbursement
Frame Allowance	\$130 allowance, 20% off balance over / \$65 allowance
Contact Lenses	\$130 allowance, 15% off balance over / \$104 allowance
Frequency	
Service Interval	Lenses or contacts every 12 months; frames every 24 months

Supplemental Benefits



Short-Term Disability

Short Term Disability Insurance is provided through Guardian. It pays a percentage of your salary if you are unable to work due to a qualifying disability. The Short Term Disability plan covers up to 60% of your salary to a \$1,500 weekly maximum. Accident and Sickness begin on the 15th day.

Long-Term Disability

The Long Term Disability Insurance is provided through Guardian and is often referred to as “paycheck insurance”, as it pays a percentage of your salary if you are unable to work due to a qualifying disability. The Long Term disability plan covers up to 60% of your income up to \$6,000 maximum per month.

Humana

Basic Life & AD&D

This plan is renewing with Humana. Employees have \$25,000 Life and AD&D coverage. This is 100% paid by your Employer.

Payroll Deductions

Talentcare will contribute 50% towards Employee only medical coverage.

Semi Monthly Payroll Employee Deductions (24)

Per Pay Period	Medical Plans			
	HE500025B HSA	HP635025B HSA	PROP200015i8021B	PROP400015i8022B
Employee Only	\$128.51	\$113.84	\$142.41	\$130.48
Employee & Spouse	\$452.81	\$398.82	\$503.97	\$460.07
Employee & Child(ren)	\$363.26	\$320.13	\$404.13	\$369.07
Employee & Family	\$689.99	\$607.25	\$768.40	\$701.12

Per Pay Period	Dental Plan
	Humana
Employee Only	\$28.07
Employee & Spouse	\$56.13
Employee & Child(ren)	\$74.31
Employee & Family	\$103.12

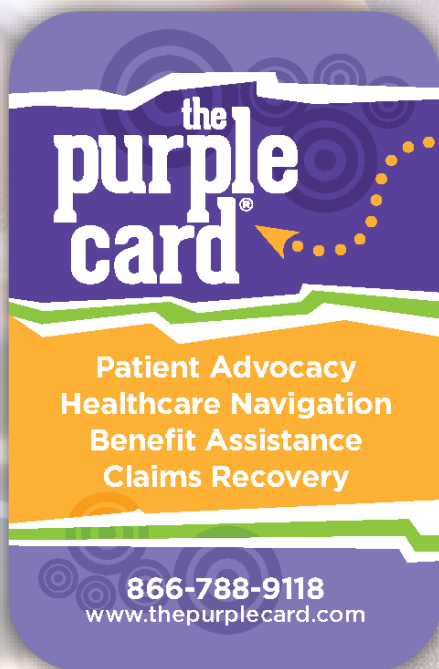
Per Pay Period	Vision Plan
	Humana
Employee Only	\$4.72
Employee & Spouse	\$9.44
Employee & Child(ren)	\$8.97
Employee & Family	\$14.09

Questions About Your Benefit Offerings?

Just Pull Out Your Purple Card and Call

866.788.9118

8:30am – 5:30pm | Monday – Friday



Talentcare continues to partner with Simpatico Benefits. Simpatico's team will ensure that you fully understand and get the most out of your employee benefit plans. You can contact The Purple Card with questions or concerns about any of your benefit plans.

Just pull out The Purple Card and call (866) 788-9118

This benefits brochure is a brief outline of certain benefits available to Talentcare employees. The details of these plans and policies are contained in the official plan and policy documents, including some insurance contracts. If there is ever a question about one of these plans and policies, or if there is a conflict between information in this booklet and the formal language of the plan or policy documents, the formal wording in the plan or policy documents will govern. Also, please note that the benefits described in this booklet may be changed at any time and does not represent a contractual obligation on the part of Talentcare.

Choice Plus plan details, all in one place.

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

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

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Summary Plan Description (SPD), that document governs. Review your SPD for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

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

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	\$4,000	\$7,500
Family	\$8,000	\$15,000

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

*After the Annual Medical Deductible has been met.

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

Annual Out-of-Pocket Limit		
Individual	\$8,150	\$15,000
Family	\$16,300	\$30,000

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

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

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care Services		No copay	50%*
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.			
Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.			
Office Services - Sickness & Injury			
Primary Care Physician			
All other covered persons	\$15 copay	\$15 copay	50%*
Covered persons less than age 19	No copay	No copay	50%*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.			
Telehealth is covered at the same cost share as in the office.			

*After the Annual Medical Deductible has been met.

*Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Designated Network	Network	Out-of-Network
--------------------	---------	----------------

Specialist

\$50 copay

\$100 copay

50% *

Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

Telehealth is covered at the same cost share as in the office.

Urgent Care Center Services

\$25 copay

50% *

Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.

Virtual Care Services

No copay

Not covered

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

Emergency Care

Ambulance Services - Emergency Ambulance

Air Ambulance

20% *

20% *

Ground Ambulance

20% *

20% *

Ambulance Services - Non-Emergency Ambulance¹

Air Ambulance

20% *

20% *

Ground Ambulance

20% *

50% *

Dental Services - Accident Only

20% *

50% *

Emergency services by an Out-of-Network provider will be considered at the Network benefit Level.

Emergency Health Care Services - Outpatient¹

You pay a \$300 per occurrence copay per visit prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20% *

You pay a \$300 per occurrence copay per visit prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20% *

Notification is required if it results in confinement to an Out-of-Network Hospital.

Inpatient Care

Habilitative Services - Inpatient

The amount you pay is based on where the covered health care service is provided.

Hospital - Inpatient Stay¹

20% *

50% *

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services¹

20% *

50% *

Limited to 60 days per year.

*After the Annual Medical Deductible has been met.

¹Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Outpatient Care			
Acupuncture Services		\$15 copay	50% *
<i>Limited to 10 treatments per year.</i>			
Habilitative Services - Outpatient			
Manipulative treatment services		\$15 copay	50% *
Other habilitative services		20% *	50% *
<i>Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.</i>			
Home Health Care ¹		20% *	50% *
<i>Limited to 30 visits per year.</i>			
<i>One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</i>			
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing ¹		20% *	50% *
<i>Limited to 18 Definitive Drug Tests per year.</i>			
<i>Limited to 18 Presumptive Drug Tests per year.</i>			
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing ¹		20% *	50% *
Major Diagnostic and Imaging - Outpatient ¹		20% *	50% *
Physician Fees for Surgical and Medical Services			
Primary care visits	20% *	20% *	50% *
Specialist care visits	20% *	20% *	50% *
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Manipulative treatment services		\$15 copay	50% *
Other rehabilitation services		20% *	50% *
<i>Limited to 20 visits of Manipulative Treatments per year.</i>			
<i>Limited to 30 combined visits of physical therapy, occupational therapy, speech therapy, cardiac therapy, post cochlear therapy, cognitive therapy and pulmonary therapy per year.</i>			
<i>Limits are combined with Habilitative Services - Outpatient.</i>			
Surgery - Outpatient ¹		20% *	50% *

*After the Annual Medical Deductible has been met.

¹Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Therapeutic Treatments - Outpatient¹

Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.

Designated Network

Network

Out-of-Network

20% *

50% *

Supplies and Services

Diabetes Self-Management Items¹

The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care¹

The amount you pay is based on where the covered health care service is provided.

Durable Medical Equipment (DME), Orthotics and Supplies¹

20% *

50% *

Enteral Nutrition

20% *

50% *

Hearing Aids

20% *

50% *

Limited to \$5,000 every 36 months ages 18 and over.

Limited to 1 Bone Anchored Hearing Aid per lifetime.

Limited to 1 hearing aid per ear every 36 months under the age of 18.

Limited to a single purchase per hearing impaired ear every 36 months.

Ostomy Supplies

20% *

50% *

Pharmaceutical Products - Outpatient

20% *

50% *

Depending on the pharmaceutical product prior authorization may be required.

This includes medications given at a doctor's office, or in a covered person's home.

Prosthetic Devices¹

20% *

50% *

Pregnancy

Pregnancy - Maternity Services¹

The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

Mental Health Care & Substance Related and Addictive Disorder Services

Inpatient

20% *

50% *

Outpatient

\$15 copay

50% *

Partial Hospitalization

20% *

50% *

Limited to 60 days combined for residential treatment facility and skilled nursing facility per year.

*After the Annual Medical Deductible has been met.

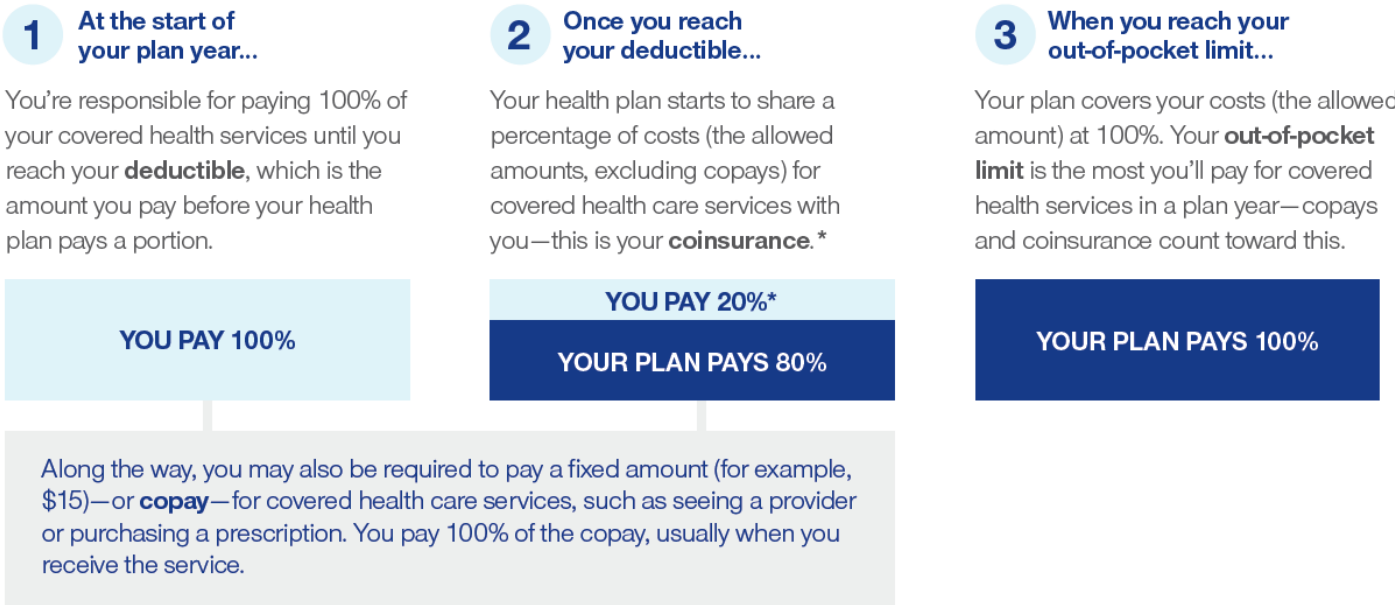
¹Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Other Services			
Cellular and Gene Therapy	The amount you pay is based on where the covered health care service is provided.		
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.			
Clinical Trials ¹	The amount you pay is based on where the covered health care service is provided.		
Gender Dysphoria ¹	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Hospice Care ¹		20% *	50% *
Reconstructive Procedures ¹	The amount you pay is based on where the covered health care service is provided.		
Transplantation Services		20% *	Not covered
Coverage is only available when services are performed at a Centers of Excellence facility, except for cornea transplants.			

*After the Annual Medical Deductible has been met.
¹Prior Authorization may be Required. Refer to SPD.

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



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

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



Search the network to find doctors.

- You can go to providers in and out of our network — but when you stay in network, you’ll likely pay less for care. To get started:
- Go to welcometouhc.com > **Benefits > Find a Doctor or Facility.**
 - Choose **Search for a health plan.**
 - Choose **Choice Plus** to view providers in the health plan’s network.



Manage your meds.

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

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



Access your plan online.

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



Get on-the-go access.

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



Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your SPD 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.

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

Outpatient Prescription Drug Benefits

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

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

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

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

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

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

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, the Prescription Drug Product is not eligible for benefits.

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

Benefits are provided for certain Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how In-Network Mail Order Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through an In-Network Mail Order Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your SPD for additional exclusions and limitations that may apply.

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

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

Online: UHC_Civil_Rights@uhc.com

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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توضيح: خدمات امداد زباني به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

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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.

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

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

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

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

PAKDAAAR: Nu saritaem ti Ilocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. 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 jíik'eh, bee ná'ahóót'i'. T'áá shodí ninaaltsoos nít'izi bee nééhozinígíí bine'déq' t'áá jíik'ehgo béesh bee hane'i biká'ígíí bee hodíilnih.

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

ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વલના મૂલ્યે પ્રાપ્ત છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિપર આપેલા સભ્ય માટેનો ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

Choice Plus plan details, all in one place.

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

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

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Summary Plan Description (SPD), that document governs. Review your SPD for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

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

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	\$2,000	\$5,000
Family	\$4,000	\$10,000

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

*After the Annual Medical Deductible has been met.

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

Annual Out-of-Pocket Limit		
Individual	\$8,150	\$10,000
Family	\$16,300	\$20,000

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

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

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care Services		No copay	50%*
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.			
Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.			
Office Services - Sickness & Injury			
Primary Care Physician			
All other covered persons	\$15 copay	\$15 copay	50%*
Covered persons less than age 19	No copay	No copay	50%*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.			
Telehealth is covered at the same cost share as in the office.			

*After the Annual Medical Deductible has been met.

*Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Designated Network	Network	Out-of-Network
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Specialist

\$50 copay

\$100 copay

50% *

Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

Telehealth is covered at the same cost share as in the office.

Urgent Care Center Services

\$25 copay

50% *

Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.

Virtual Care Services

No copay

Not covered

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

Emergency Care

Ambulance Services - Emergency Ambulance

Air Ambulance

20% *

20% *

Ground Ambulance

20% *

20% *

Ambulance Services - Non-Emergency Ambulance¹

Air Ambulance

20% *

20% *

Ground Ambulance

20% *

50% *

Dental Services - Accident Only

20% *

50% *

Emergency services by an Out-of-Network provider will be considered at the Network benefit Level.

Emergency Health Care Services - Outpatient¹

You pay a \$300 per occurrence copay per visit prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20% *

You pay a \$300 per occurrence copay per visit prior to and in addition to paying any Annual Deductible and any coinsurance amount. 20% *

Notification is required if it results in confinement to an Out-of-Network Hospital.

Inpatient Care

Habilitative Services - Inpatient

The amount you pay is based on where the covered health care service is provided.

Hospital - Inpatient Stay¹

20% *

50% *

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services¹

20% *

50% *

Limited to 60 days per year.

*After the Annual Medical Deductible has been met.

¹Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Outpatient Care			
Acupuncture Services		\$15 copay	50% *
<i>Limited to 10 treatments per year.</i>			
Habilitative Services - Outpatient			
Manipulative treatment services		\$15 copay	50% *
Other habilitative services		20% *	50% *
<i>Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.</i>			
Home Health Care ¹		20% *	50% *
<i>Limited to 30 visits per year.</i>			
<i>One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</i>			
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing ¹		20% *	50% *
<i>Limited to 18 Definitive Drug Tests per year.</i>			
<i>Limited to 18 Presumptive Drug Tests per year.</i>			
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing ¹		20% *	50% *
Major Diagnostic and Imaging - Outpatient ¹		20% *	50% *
Physician Fees for Surgical and Medical Services			
Primary care visits	20% *	20% *	50% *
Specialist care visits	20% *	20% *	50% *
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Manipulative treatment services		\$15 copay	50% *
Other rehabilitation services		20% *	50% *
<i>Limited to 20 visits of Manipulative Treatments per year.</i>			
<i>Limited to 30 combined visits of physical therapy, occupational therapy, speech therapy, cardiac therapy, post cochlear therapy, cognitive therapy and pulmonary therapy per year.</i>			
<i>Limits are combined with Habilitative Services - Outpatient.</i>			
Surgery - Outpatient ¹		20% *	50% *

*After the Annual Medical Deductible has been met.

¹Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Therapeutic Treatments - Outpatient¹

Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.

Designated Network

Network

Out-of-Network

20% *

50% *

Supplies and Services

Diabetes Self-Management Items¹

The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care¹

The amount you pay is based on where the covered health care service is provided.

Durable Medical Equipment (DME), Orthotics and Supplies¹

20% *

50% *

Enteral Nutrition

20% *

50% *

Hearing Aids

20% *

50% *

Limited to \$5,000 every 36 months ages 18 and over.

Limited to 1 Bone Anchored Hearing Aid per lifetime.

Limited to 1 hearing aid per ear every 36 months under the age of 18.

Limited to a single purchase per hearing impaired ear every 36 months.

Ostomy Supplies

20% *

50% *

Pharmaceutical Products - Outpatient

20% *

50% *

Depending on the pharmaceutical product prior authorization may be required.

This includes medications given at a doctor's office, or in a covered person's home.

Prosthetic Devices¹

20% *

50% *

Pregnancy

Pregnancy - Maternity Services¹

The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

Mental Health Care & Substance Related and Addictive Disorder Services

Inpatient

20% *

50% *

Outpatient

\$15 copay

50% *

Partial Hospitalization

20% *

50% *

Limited to 60 days combined for residential treatment facility and skilled nursing facility per year.

*After the Annual Medical Deductible has been met.

¹Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Other Services			
Cellular and Gene Therapy	The amount you pay is based on where the covered health care service is provided.		
For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.			
Clinical Trials ¹	The amount you pay is based on where the covered health care service is provided.		
Gender Dysphoria ¹	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Hospice Care ¹		20% *	50% *
Reconstructive Procedures ¹	The amount you pay is based on where the covered health care service is provided.		
Transplantation Services		20% *	Not covered
Coverage is only available when services are performed at a Centers of Excellence facility, except for cornea transplants.			

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



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

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



Search the network to find doctors.

- You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:
- Go to welcometouhc.com > **Benefits > Find a Doctor or Facility.**
 - Choose **Search for a health plan.**
 - Choose **Choice Plus** to view providers in the health plan's network.



Manage your meds.

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

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



Access your plan online.

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



Get on-the-go access.

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



Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your SPD 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.

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

Outpatient Prescription Drug Benefits

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

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

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

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

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

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

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, the Prescription Drug Product is not eligible for benefits.

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

Benefits are provided for certain Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how In-Network Mail Order Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through an In-Network Mail Order Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your SPD for additional exclusions and limitations that may apply.

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

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

Online: UHC_Civil_Rights@uhc.com

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

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

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

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

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

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

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

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

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

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

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

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

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DÍÍ BAA'ÁKONÍNÍZIN: Diné (**Navajo**) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíik'eh, bee ná'ahóót'i'. T'áá shóodí ninaaltsoos nítł'izi bee nééhozinígíí bine'déq' t'áá jíik'ehgo béesh bee hane'i biká'ígíí bee hodíilnih.

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

ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વલના મૂલ્યે પ્રાપ્ત છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિપર આપેલા સભ્ય માટેનો ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

Choice Plus plan details, all in one place.

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

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

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Summary Plan Description (SPD), that document governs. Review your SPD for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

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

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	\$6,350	\$12,700
Family	\$12,700	\$25,400

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

*After the Annual Medical Deductible has been met.

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

Annual Out-of-Pocket Limit		
Individual	\$6,350	\$25,400
Family	\$12,700	\$50,800

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

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

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Preventive Care Services		
Preventive Care Services	No copay	50%*
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.		
Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.		
Office Services - Sickness & Injury		
Primary Care Physician	No copay*	50%*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.		
Telehealth is covered at the same cost share as in the office.		
Specialist	No copay*	50%*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.		
Telehealth is covered at the same cost share as in the office.		

*After the Annual Medical Deductible has been met.

*Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Urgent Care Center Services

No copay *

50% *

Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.

Virtual Care Services

No copay *

Not covered

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

Emergency Care

Ambulance Services - Emergency Ambulance

Air Ambulance

No copay *

No copay *

Ground Ambulance

No copay *

No copay *

Ambulance Services - Non-Emergency Ambulance¹

Air Ambulance

No copay *

No copay *

Ground Ambulance

No copay *

50% *

Dental Services - Accident Only

No copay *

50% *

Emergency services by an Out-of-Network provider will be considered at the Network benefit Level.

Emergency Health Care Services - Outpatient¹

No copay *

No copay *

Notification is required if it results in confinement to an Out-of-Network Hospital.

Inpatient Care

Habilitative Services - Inpatient

The amount you pay is based on where the covered health care service is provided.

Hospital - Inpatient Stay¹

No copay *

50% *

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services¹

No copay *

50% *

Limited to 60 days per year.

Outpatient Care

Acupuncture Services

No copay *

50% *

Limited to 10 treatments per year.

*After the Annual Medical Deductible has been met.

¹Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network	Out-of-Network
Habilitative Services - Outpatient		
Manipulative treatment services	No copay*	50%*
Other habilitative services	No copay*	50%*
<i>Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.</i>		
Home Health Care ¹	No copay*	50%*
<i>Limited to 30 visits per year.</i>		
<i>One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</i>		
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing ¹	No copay*	50%*
<i>Limited to 18 Definitive Drug Tests per year.</i>		
<i>Limited to 18 Presumptive Drug Tests per year.</i>		
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing ¹	No copay*	50%*
Major Diagnostic and Imaging - Outpatient ¹	No copay*	50%*
Physician Fees for Surgical and Medical Services	No copay*	50%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Manipulative treatment services	No copay*	50%*
Other rehabilitation services	No copay*	50%*
<i>Limited to 20 visits of Manipulative Treatments per year.</i>		
<i>Limited to 30 combined visits of physical therapy, occupational therapy, speech therapy, cardiac therapy, post cochlear therapy, cognitive therapy and pulmonary therapy per year.</i>		
<i>Limits are combined with Habilitative Services - Outpatient.</i>		
Surgery - Outpatient ¹	No copay*	50%*
Therapeutic Treatments - Outpatient ¹	No copay*	50%*
<i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.</i>		
Supplies and Services		
Diabetes Self-Management Items ¹	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care ¹	The amount you pay is based on where the covered health care service is provided.	
Durable Medical Equipment (DME), Orthotics and Supplies ¹	No copay*	50%*

*After the Annual Medical Deductible has been met.

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What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Enteral Nutrition	No copay *	50% *
Hearing Aids	No copay *	50% *
<i>Limited to \$5,000 every 36 months ages 18 and over.</i>		
<i>Limited to 1 Bone Anchored Hearing Aid per lifetime.</i>		
<i>Limited to 1 hearing aid per ear every 36 months under the age of 18.</i>		
<i>Limited to a single purchase per hearing impaired ear every 36 months.</i>		
Ostomy Supplies	No copay *	50% *
Pharmaceutical Products - Outpatient	No copay *	50% *
<i>Depending on the pharmaceutical product prior authorization may be required.</i>		
<i>This includes medications given at a doctor's office, or in a covered person's home.</i>		
Prosthetic Devices ¹	No copay *	50% *
Pregnancy		
Pregnancy - Maternity Services ¹	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient	No copay *	50% *
Outpatient	No copay *	50% *
Partial Hospitalization	No copay *	50% *
<i>Limited to 60 days combined for residential treatment facility and skilled nursing facility per year.</i>		
Other Services		
Cellular and Gene Therapy	The amount you pay is based on where the covered health care service is provided.	
<i>For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.</i>		
Clinical Trials ¹	The amount you pay is based on where the covered health care service is provided.	
Gender Dysphoria ¹	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Hospice Care ¹	No copay *	50% *
Reconstructive Procedures ¹	The amount you pay is based on where the covered health care service is provided.	
Transplantation Services	No copay *	Not covered
<i>Coverage is only available when services are performed at a Centers of Excellence facility, except for cornea transplants.</i>		

*After the Annual Medical Deductible has been met.

¹Prior Authorization may be Required. Refer to SPD.

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

1 At the start of your plan year...

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

YOU PAY 100%

2 Once you reach your deductible...

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

YOU PAY 20%*

YOUR PLAN PAYS 80%

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

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

YOUR PLAN PAYS 100%

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

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

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



Search the network to find doctors.

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

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



Manage your meds.

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

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



Access your plan online.

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



Get on-the-go access.

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

Good stuff
that's good
to know.

I dig it!

Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your SPD 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.

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

Outpatient Prescription Drug Benefits

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

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

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

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

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

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

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, the Prescription Drug Product is not eligible for benefits.

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

Benefits are provided for certain Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how In-Network Mail Order Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through an In-Network Mail Order Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your SPD for additional exclusions and limitations that may apply.

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

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

Online: UHC_Civil_Rights@uhc.com

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

توضيح: خدمات امداد زباني به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

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.

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ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વલના મૂલ્યે પ્રાપ્ત છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિપર આપેલા સભ્ય માટેનો ટોલ-ફ્રી નંબર ઉપર કોલ કરો.

Choice plan details, all in one place.

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

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

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Summary Plan Description (SPD), that document governs. Review your SPD for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

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

Medical Benefits

In Network	
Annual Medical Deductible	
Individual	\$5,000
Family	\$10,000
All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.	
*After the Annual Medical Deductible has been met.	
You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.	
Annual Out-of-Pocket Limit	
Individual	\$5,000
Family	\$10,000
All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.	
Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.	

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services	Network
Preventive Care Services	
Preventive Care Services	No copay
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.	
Includes services such as Routine Wellness Checkups, Immunizations, Breast Pumps, Mammography and Colorectal Cancer Screenings.	
Office Services - Sickness & Injury	
Primary Care Physician	No copay*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.	
Telehealth is covered at the same cost share as in the office.	
Specialist	No copay*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.	
Telehealth is covered at the same cost share as in the office.	

*After the Annual Medical Deductible has been met.

*Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Urgent Care Center Services

No copay*

Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.

Virtual Care Services

No copay*

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.

Emergency Care

Ambulance Services - Emergency Ambulance

Air Ambulance

No copay*

Ground Ambulance

No copay*

Ambulance Services - Non-Emergency Ambulance

Air Ambulance

No copay*

Ground Ambulance

No copay*

Dental Services - Accident Only

No copay*

Emergency Health Care Services - Outpatient¹

No copay*

Notification is required if it results in confinement to an Out-of-Network Hospital.

Inpatient Care

Habilitative Services - Inpatient

The amount you pay is based on where the covered health care service is provided.

Hospital - Inpatient Stay

No copay*

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

No copay*

Limited to 60 days per year.

Outpatient Care

Acupuncture Services

No copay*

Limited to 10 treatments per year.

Habilitative Services - Outpatient

Manipulative treatment services

No copay*

Other habilitative services

No copay*

Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment.

*After the Annual Medical Deductible has been met.

¹Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

	Network
Home Health Care	No copay*
<i>Limited to 30 visits per year.</i>	
<i>One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.</i>	
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing	No copay*
<i>Limited to 18 Definitive Drug Tests per year.</i>	
<i>Limited to 18 Presumptive Drug Tests per year.</i>	
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing	No copay*
Major Diagnostic and Imaging - Outpatient	No copay*
Physician Fees for Surgical and Medical Services	No copay*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	
Manipulative treatment services	No copay*
Other rehabilitation services	No copay*
<i>Limited to 20 visits of Manipulative Treatments per year.</i>	
<i>Limited to 30 combined visits of physical therapy, occupational therapy, speech therapy, cardiac therapy, post cochlear therapy, cognitive therapy and pulmonary therapy per year.</i>	
<i>Limits are combined with Habilitative Services - Outpatient.</i>	
Surgery - Outpatient	No copay*
Therapeutic Treatments - Outpatient	No copay*
<i>Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.</i>	
Supplies and Services	
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 Prescription Drug Benefits Section.
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.
Durable Medical Equipment (DME), Orthotics and Supplies	No copay*
Enteral Nutrition	No copay*

*After the Annual Medical Deductible has been met.

*Prior Authorization may be Required. Refer to SPD.

What You Pay for Services

Copays (\$) and Coinsurance (%) for Covered Health Care Services

Hearing Aids

No copay*

Limited to \$5,000 every 36 months ages 18 and over.

Limited to 1 Bone Anchored Hearing Aid per lifetime.

Limited to 1 hearing aid per ear every 36 months under the age of 18.

Limited to a single purchase per hearing impaired ear every 36 months.

Ostomy Supplies

No copay*

Pharmaceutical Products - Outpatient

No copay*

Depending on the pharmaceutical product prior authorization may be required.

This includes medications given at a doctor's office, or in a covered person's home.

Prosthetic Devices

No copay*

Pregnancy

Pregnancy - Maternity Services

The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

Mental Health Care & Substance Related and Addictive Disorder Services

Inpatient

No copay*

Outpatient

No copay*

Partial Hospitalization

No copay*

Limited to 60 days combined for residential treatment facility and skilled nursing facility per year.

Other Services

Cellular and Gene Therapy

The amount you pay is based on where the covered health care service is provided.

Cellular or Gene Therapy services must be received from a Designated Provider.

Clinical Trials

The amount you pay is based on where the covered health care service is provided.

Gender Dysphoria

The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.

Hospice Care

No copay*

Reconstructive Procedures

The amount you pay is based on where the covered health care service is provided.

Transplantation Services

No copay*

Coverage is only available when services are performed at a Centers of Excellence facility, except for cornea transplants.

*After the Annual Medical Deductible has been met.

*Prior Authorization may be Required. Refer to SPD.

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



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

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



Search the network to find doctors.

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

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



Manage your meds.

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

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



Access your plan online.

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



Get on-the-go access.

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



Other important information about your benefits.

Medical Exclusions

Services your plan generally does NOT cover. It is recommended that you review your SPD 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.

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

Outpatient Prescription Drug Benefits

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

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

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

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

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

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

If you require certain Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, the Prescription Drug Product is not eligible for benefits.

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

Benefits are provided for certain Prescription Drug Products dispensed by an In-Network Mail Order Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how In-Network Mail Order Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through an In-Network Mail Order Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your SPD for additional exclusions and limitations that may apply.

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

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

Online: UHC_Civil_Rights@uhc.com

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

توضيح: خدمات امداد زباني به طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

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. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

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

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

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

PAKDAAAR: Nu saritaem ti Ilocano (**Ilocano**), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. 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 jíik'eh, bee ná'ahóót'i'. T'áá shoodí ninaaltsoos nít'izi bee nééhozinígíí bine'déq' t'áá jíik'ehgo béesh bee hane'i biká'ígíí bee hodíilnih.

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ગુજરાતી (Gujarati): ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વલના મૂલ્યે પ્રાપ્ત છે. મહેરબાની કરી તમારા આઈડી કાર્ડની સૂચિપર આપેલા સભ્ય માટેનો ટોલ-ફ્રી નંબર ઉપર કોલ કરો.



Services	In-network dentist		Out-of-network dentist U&C 90	
Deductible (excludes orthodontia services)	Individual: \$50	Family: \$150	Individual: \$50	Family: \$150
Deductible applies to all services excluding preventive services.				
Annual maximum (excludes orthodontia services)	\$1,500 + extended annual maximum (see section below)			
Preventive services Routine oral examinations (2 per year) Bitewing x-rays (2 films under age 10, up to 4 films ages 10 and older) Panoramic x-rays (1 per 5 years combined, Panorex and Full Mouth X-rays share the same frequency; ages 6+) Routine cleanings (2 per year) Fluoride treatment (1 per year, through age 14) Sealants (permanent molars, through age 14) Space maintainers (primary teeth, through age 14) Oral Cancer Screening (1 per year, ages 40 and older)	100% no deductible		100% no deductible	
Basic services Emergency care for pain relief Amalgam fillings (1 per tooth every 2 years, composite for anterior/front teeth) Oral surgery (including extractions of impacted teeth) General anesthesia¹ Stainless steel crowns Harmful habit appliances for children (1 per lifetime, through age 14)	80% after deductible		80% after deductible	
Major services Crowns (1 per tooth every 5 years) Inlays/onlays (1 per tooth every 5 years) Bridges (1 every 5 years) Dentures (1 every 5 years) Denture relines/rebases (1 every 3 years, following 6 months of denture use) Denture repair and adjustments (following 6 months of denture use)	50% after deductible		50% after deductible	

¹ Only covered in conjunction with covered oral surgical procedures. Other restrictions may apply.



Humana Dental Traditional Plus 14

TX Trad+ O1K U&C 100/80/50
TALENTCARE LLC

TEXAS

Services	In-network dentist	Out-of-network dentist U&C 90
Periodontics (periodontal cleanings 4 per year, scaling/root planing and surgery 1 per quadrant every 3 years) Endodontics (root canals 1 per tooth per lifetime and 1 re-treatment)		
Extended Annual Max Additional coverage for preventive, basic, and major services after the annual maximum is met (excludes orthodontia)	30%	30%

Orthodontia services Adult/Child orthodontia - Plan pays 50 percent (no deductible) of the covered orthodontia services, up to: \$1,000 lifetime orthodontia maximum.

Humana will reimburse out-of-network claims based on internal and external data (including FairHealth industry benchmarks) to establish reimbursement limits by geographic region. Out of network dentists may bill members for charges above the amount covered by the dental plan.

Waiting periods

Enrollment type ²	Group size	Preventive	Basic	Major ³	Orthodontia
Initial enrollment, open enrollment, and timely add-on	2-9 enrolled employees	No	No	12 months ⁴	24 months ⁴
Initial enrollment, open enrollment, and timely add-on	10 or more enrolled employees	No	No	No	12 months ⁴ (No waiting period for employer-sponsored)

² Late applicant enrollment will have the following waiting periods: 12 months basic & major services, 12 months orthodontia (24 months for 2-9 enrolled employees.)
³ Waiting periods do not apply to endodontic services unless a late applicant.
⁴ Waiting periods may be decreased or waived based on the number of months the member had dental insurance immediately before their effective date. Members must have prior orthodontic insurance to reduce or waive the orthodontic waiting period.



Questions?

Visit [Humana.com](https://www.humana.com) or call 866-427-7478
Monday – Saturday, 8 a.m. – 11 p.m., and
Sunday, 11 a.m. – 8 p.m., Eastern time.
Find a dentist at [Humana.com/findadentist](https://www.humana.com/findadentist).



Register today!

Register or sign in to MyHumana at [Humana.com](https://www.humana.com) to view your coverage details, ID cards, manage claims, find a dentist and more!



Humana Dental Traditional Plus 14

TX Trad+ O1K U&C 100/80/50

TALENTCARE LLC

TEXAS

Missing tooth clause:
See plan document for more details.

Insured by Humana Insurance Company.

This is not a complete disclosure of plan qualifications and limitations. Your agents will provide you with specific limitations and exclusions as contained in the Regulatory and Technical Information Guide. Please review this information before applying for coverage. The amount of benefits provided depends upon the plan selected. Premiums will vary according to the selection made.

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GCHJV5REN 0721



Services	In-network provider (Member cost)	Out-of-network provider (Reimbursement)
Exam with dilation as necessary	\$10	Up to \$30
Retinal imaging* ¹	Up to \$39	Not covered
Contact lens exam²		
Standard contact lens fit and follow-up*	Up to \$40	Not covered
Premium contact lens fit and follow-up*	10% off retail	Not covered
Frames³	\$130 allowance, 20% off balance over \$130	\$65 allowance
Standard plastic lenses		
Single vision	\$15	Up to \$25
Bifocal	\$15	Up to \$40
Trifocal	\$15	Up to \$60
Lenticular	\$15	Up to \$100
Lens options⁴		
UV coating*	\$15	Not covered
Tint (solid and gradient)*	\$15	Not covered
Standard scratch-resistance*	\$15	Not covered
Standard polycarbonate - Adults*	\$40	Not covered
Standard polycarbonate - Children <19*	\$40	Not covered
Standard anti-reflective coating*	\$45	Not covered
Premium anti-reflective coating*		
• Tier 1	\$57	Not covered
• Tier 2	\$68	Not covered
• Tier 3	20% off retail	Not covered
Standard progressive (add-on to bifocal)	\$15	Up to \$40
Premium progressive*		
• Tier 1	\$110	Not covered
• Tier 2	\$120	Not covered
• Tier 3	\$135	Not covered
• Tier 4	\$90 copay, 80% of charge less \$120 allowance	Not covered
Photochromatic / Plastic transitions*	\$75	Not covered
Polarized*	20% off retail	Not covered

* This service is not a covered benefit under your insurance policy. However, this service may be available to members from participating providers at the discounted rate shown. Members should confirm pricing with their provider.



Services	In-network provider (Member cost)	Out-of-network provider (Reimbursement)
Contact lenses⁵ (applies to materials only)		
Conventional	\$130 allowance, 15% off balance over \$130	\$104 allowance
Disposable	\$130 allowance \$0	\$104 allowance \$200 allowance
Medically necessary		
Frequency		
Examination	Once every 12 months	Once every 12 months
Lenses or contact lenses	Once every 12 months	Once every 12 months
Frame	Once every 24 months	Once every 24 months
Diabetic eye care: Care and testing for diabetic members		
Examination	\$0	Up to \$77
• Up to (2) services per year		
Retinal imaging	\$0	Up to \$50
• Up to (2) services per year		
Extended Ophthalmoscopy	\$0	Up to \$15
• Up to (2) services per year		
Gonioscopy	\$0	Up to \$15
• Up to (2) services per year		
Scanning laser	\$0	Up to \$33
• Up to (2) services per year		

¹Member costs may exceed \$39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.

²Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.

³Discounts may be available on all frames except when prohibited by the manufacturer.

⁴Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.

⁵Plan covers contact lenses or lenses for frames, but not both.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name vision materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members may receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. Since Lasik or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.



Humana Vision 130
TALENTCARE LLC

TEXAS



Questions?

Visit **Humana.com** or call **877-398-2980**
Monday – Saturday, 8 a.m. – 11 p.m., and
Sunday, 11 a.m. – 8 p.m., Eastern time.
Find a vision provider at **Humana.com/find-care**.



Register today!

Register or sign in to MyHumana at **Humana.com**
to view your coverage details, ID cards, manage
claims, find a vision provider and more!



Limitations and exclusions (all services):

In addition to the limitations and exclusions listed in your "**Vision Benefits**" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - War or any act of war, whether declared or not;
 - Any act of international armed conflict- or
 - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
 - Is not a visual necessity;
 - Does not offer a favorable prognosis;
 - Does not have uniform professional endorsement; or
 - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

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This communication provides a general description of certain identified insurance or non-insurance benefits provided under one or more of our insurance benefit plans. Our insurance benefit plans have exclusions and limitations and terms under which the coverage may be continued in force or discontinued. For costs and complete details of the coverage, refer to the plan document or call or write your Humana insurance agent or the company. In the event of any disagreement between this communication and the plan document, the plan document will control.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

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Coverage	Loss	Benefit	
Life insurance	Death	Your beneficiary will receive \$25,000.	
Accelerated death benefit	Terminal illness with a life-expectancy of 24 months or less.	50 percent of the life benefit amount to a maximum benefit of \$250,000. The final life benefit amount will be reduced by the amount of the accelerated death benefit paid (may vary by state).	
Dependent insurance	Death of spouse. Death of dependent child (Some limitations apply. No benefit for birth through 14 days. Reduced benefit for age 15 days to 6 months).	No dependent coverage selected. No dependent coverage selected.	
Accidental death or bodily injury (AD&D) ¹	Loss of Life / Dismemberment*	Benefit: Non common carrier accident	Benefit: Common carrier accident
	Loss of life	100%	200%
	Loss of both hands	100%	200%
	Loss of both limbs	100%	200%
	Loss of both legs	100%	200%
	Loss of both feet	100%	200%
	Loss of sight in both eyes	100%	200%
	Loss of one hand and one foot	100%	200%
	Loss of one hand or one foot and sight of one eye	100%	200%
	Quadriplegia	100%	200%
	Paraplegia	50%	100%
	Hemiplegia	50%	100%
	Loss of one hand	50%	100%
	Loss of one arm	50%	100%
	Loss of one leg	50%	100%
	Loss of one foot	50%	100%
	Loss of sight of one eye	50%	100%
	*Reimbursement percentages for each benefit based on principle amount.		

¹The total benefit for all losses resulting from the same accident will be limited to the one type of loss which provides the greatest benefit. This is in addition to the life benefit amount.



AD&D includes the following benefits:

Seat belt-airbag helmet benefit	Death as the result of an auto accident while properly using a seat belt, or wearing a properly fitted and fastened motorcycle helmet in a motorcycle accident.	Amount of your accidental death benefit increases by 10 percent, but not less than \$1,000 or more than \$10,000. In addition, we will increase your accidental death benefit by 5 percent, to a maximum of \$5,000 but no less than \$500, for a properly functioning airbag.
Education benefit	Death as the result of an accident.	Actual expense to a maximum of \$5,000 or 5 percent of death benefit. Payable up to four years for employee's dependent children or until age 25. Dependent must be a full-time student beyond 12th grade at a college, university or vocational school on the date of the employee's death or within 365 days after the death.
Childcare benefit	Death as the result of an accident.	Actual expense to a maximum of \$5,000 or 5 percent of death benefit. For a dependent in a licensed childcare center up to four consecutive years after the employee's death, or until the child's 13th birthday.
Coma benefit	Employee is in a coma caused by a body injury, the coma begins within 365 days after the accident; and the person remains in a coma for more than 31 consecutive days.	One time payment of 5 percent of the employee's benefit, subject to a maximum of \$5,000.
Repatriation benefit	Death as the result of an accident.	Actual expenses to a maximum of \$5,000 if employee dies as a result of an accidental death at least 150 miles from his/her principal place of resident, and there are expenses for preparing and transporting the employee's body to a mortuary.
Spouse training benefit	Death as the result of an accident.	Actual expense to a maximum of \$5,000 or 5 percent of death benefit for one year after the employee's death. Survivor must be enrolled as a student in an accredited school on the date of the employee's death or within 365 days after the death.



Age reduction schedule

Beginning at age 65 (or age 70 in schedule three), employee life coverage will reduce based on the benefit amount in force on the employee's 64th birthday (or age 69 in schedule three). Spouse benefits reduce based on spouse's age.

Age	Schedule two
65	35 percent
70	50 percent
75	No further reduction
80	
85+	

Eligibility to participate

Active, full-time employees are eligible for coverage.

Waiver of premium

If you are totally disabled for at least six consecutive months prior to age 60, you can continue life insurance coverage and waive the premium. Waiver ends at age 65 or 70 (see certificate for benefit details).

Conversion privilege

If your employment ends, you may be eligible to convert your coverage to an individual whole life insurance policy.



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