

Medical Insurance Premiums & Additional Information

The Summary of Benefits and Coverage (SBC), provided in addition to this Employee Benefits Highlights Booklet, is your primary source of information regarding your United Healthcare medical plans. The information contained in this Booklet regarding your medical plans is intended to supplement your SBC and accompanying definitions. If any information in this booklet unintentionally conflicts with the SBC or accompanying definitions, the SBC information prevails. If you have any additional questions regarding the plan please contact United Healthcare's Customer Service at (800) 357-0978.

The City provides medical insurance through United Healthcare to benefit eligible employees. The costs per pay period for coverage are listed in the premium table below. **For information about your medical plan please refer to the Summary of Benefits and Coverage (SBC) provided.**

Medical Insurance – Choice Plus Plan 004 24 Payroll Deductions

Tier of Coverage	Employee Cost
Employee Only	\$0.00
Employee + Spouse	\$121.44
Employee + Child(ren)	\$81.34
Employee + Family	\$310.49

Medical Insurance – Choice Plus Plan 003 24 Payroll Deductions

Tier of Coverage	Employee Cost
Employee Only	\$11.39
Employee + Spouse	\$145.36
Employee + Child(ren)	\$103.55
Employee + Family	\$345.23

Medical Insurance – Choice Plus Plan 001 24 Payroll Deductions

Tier of Coverage	Employee Cost
Employee Only	\$44.99
Employee + Spouse	\$215.98
Employee + Child(ren)	\$169.05
Employee + Family	\$448.90

How To Locate A Provider

To search for a participating provider, go to www.uhc.com, click "Find a Doctor" and select "Search for a Doctor." Select "United Healthcare Choice Plus" for the plan then complete the search criteria.

Other Available Plan Resources

United Healthcare offers enrolled members and dependents additional services and discounts through value added programs. **For more details regarding other available plan resources, please refer to your Summary of Benefits and Coverage (SBC).**

Discount Programs & Services

UnitedHealth Allies is a FREE member discount program and offers all members access to discounted health and wellness programs at participating providers. Members can call (800) 860-8773 or log on to www.myuhc.com and select health and wellness; the health discount program; and Exclusive Health Discounts to learn more about these programs:

- Dental Care
- Vision Care
- Hearing Products
- Laser Vision Correction Services
- Fitness Programs
- Weight Management Programs & Nutrition Counseling
- Tobacco Cessation
- Alternative Medicine
- Health Supplies
- Long Term Care

Medical Insurance: Choice Plus Plan 004 At-A-Glance

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Network	Choice Plus	
Calendar Year Deductible (CYD)	In Network	Out of Network
Single	\$500	\$1,000
Family	\$1,000	\$2,000
Coinsurance	In Network	Out of Network
Member Responsibility	20%	30%
Calendar Year Out-of-Pocket Limit	In Network	Out of Network
Single	\$3,000	\$6,000
Family	\$6,000	\$12,000
What Applies to the Out-of-Pocket Limit	Coinsurance and Deductible (<i>Excludes Copays for some services</i>)	
Physician Services	In Network	Out of Network*
Physician Office Visit	\$20 Copay	30% After CYD
Specialist Office Visit	\$40 Copay	
Diagnostic Services	In Network	Out of Network*
Clinical Lab (Blood Work) at Independent Facility	No Charge	30% After CYD
X-rays at Independent Facility	No Charge	
Advanced Imaging (MRI, PET, CT)	20% After CYD	
Hospital Services	In Network	Out of Network*
Inpatient	20% After CYD	30% After CYD
Outpatient Surgery	20% After CYD	30% After CYD
Physician Services at Hospital or Outpatient Facility	20% After CYD	30% After CYD
Emergency Room (Waived if Admitted)	\$125 Copay	\$125 Copay
Urgent Care Center	\$35 Copay	30% After CYD
Mental Health / Alcohol & Substance Abuse	In Network	Out of Network*
Inpatient (Prior Authorization Required)	20% After CYD	30% After CYD
Outpatient (Prior Authorization Required) (Per Visit)	\$20 Copay	
Prescription Drugs (Rx)	In Network	Out of Network*
Tier 1	\$10 Copay	\$10 Copay
Tier 2	\$30 Copay	\$30 Copay
Tier 3	\$50 Copay	\$50 Copay
Mail Order Drug (90 Day Supply)	\$25 / \$75 / \$125 Copay	No Coverage

*Out-Of-Network Balance Billing

For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).

Medical Insurance: Choice Plus Plan 003 At-A-Glance

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Network	Choice Plus	
	In Network	Out of Network
Calendar Year Deductible (CYD)		
Single	\$500	\$1,000
Family	\$1,000	\$2,000
Coinsurance		
Member Responsibility	10%	30%
Calendar Year Out-of-Pocket Limit		
Single	\$2,500	\$5,000
Family	\$5,000	\$10,000
What Applies to the Out-of-Pocket Limit	Coinsurance and Deductible (<i>Excludes Copays for some services</i>)	
Physician Services	In Network	Out of Network*
Physician Office Visit	\$15 Copay	30% After CYD
Specialist Office Visit	\$30 Copay	
Diagnostic Services	In Network	Out of Network*
Clinical Lab (Blood Work) at Independent Facility	No Charge	30% After CYD
X-rays at Independent Facility	No Charge	
Advanced Imaging (MRI, PET, CT)	10% After CYD	
Hospital Services	In Network	Out of Network*
Inpatient	10% After CYD	30% After CYD
Outpatient Surgery	10% After CYD	30% After CYD
Physician Services at Hospital or Outpatient Facility	10% After CYD	30% After CYD
Emergency Room (Waived if Admitted)	\$125 Copay	\$125 Copay
Urgent Care Center	\$35 Copay	30% After CYD
Mental Health / Alcohol & Substance Abuse	In Network	Out of Network*
Inpatient (Prior Authorization Required)	10% After CYD	30% After CYD
Outpatient (Prior Authorization Required)	\$15 Copay	
Prescription Drugs (Rx)	In Network	Out of Network*
Tier 1	\$10 Copay	\$10 Copay
Tier 2	\$30 Copay	\$30 Copay
Tier 3	\$50 Copay	\$50 Copay
Mail Order Drug (90 Day Supply)	\$25 / \$75 / \$125 Copay	No Coverage

*Out-Of-Network Balance Billing

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Medical Insurance: Choice Plus Plan 001 At-A-Glance

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Network	Choice Plus	
	In Network	Out of Network
Calendar Year Deductible (CYD)		
Single	\$250	\$500
Family	\$500	\$1,000
Coinsurance	In Network	Out of Network
Member Responsibility	0%	30%
Calendar Year Out-of-Pocket Limit	In Network	Out of Network
Single	\$2,000	\$4,000
Family	\$4,000	\$8,000
What Applies to the Out-of-Pocket Limit	Coinsurance and Deductible (<i>Excludes Copays for some services</i>)	
Physician Services	In Network	Out of Network*
Physician Office Visit	\$10 Copay	30% After CYD
Specialist Office Visit	\$20 Copay	
Diagnostic Services	In Network	Out of Network*
Clinical Lab (Blood Work) at Independent Facility	No Charge	30% After CYD
X-rays at Independent Facility	No Charge	
Advanced Imaging (MRI, PET, CT)	\$100 Copay	
Hospital Services	In Network	Out of Network*
Inpatient	0% After CYD	30% After CYD
Outpatient Surgery	\$100 Copay	30% After CYD
Physician Services at Hospital or Outpatient Facility	0% After CYD	30% After CYD
Emergency Room (Waived if Admitted)	\$100 Copay	\$100 Copay
Urgent Care Center	\$35 Copay	30% After CYD
Mental Health / Alcohol & Substance Abuse	In Network	Out of Network*
Inpatient (Prior Authorization Required)	0% After CYD	30% After CYD
Outpatient (Prior Authorization Required)	\$10 Copay	
Prescription Drugs (Rx)	In Network	Out of Network*
Tier 1	\$10 Copay	\$10 Copay
Tier 2	\$30 Copay	\$30 Copay
Tier 3	\$50 Copay	\$50 Copay
Mail Order Drug (90 Day Supply)	\$25 / \$75 / \$125 Copay	No Coverage

*Out-Of-Network Balance Billing

For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-of-Network Benefits section on the Summary of Benefits and Coverage (SBC).