## **Teammate Benefits Plans**

Network   Catendar Year Deductible (Individual / Family)   \$0.030   \$3,000 / \$5,000	IN-NETWORK MEDICAL BENEFITS	BLUE PLAN	BRONZE PLAN			AN
Maximum Calendar Year Out of Pocket (Individual / Family)	Network	UnitedHealthcare Options PPO	UnitedHealthcare Choice Plus			ce Plus
PROFESSIONAL SERVICES   Your responsibility is:   S5 Copay, first 2 visits, \$25 Copay, visits 3 to 6   \$5 Copay   Visits \$5 Copay, visits 3 to 6   \$5 Copay   Visits \$5 Copay	Calendar Year Deductible (Individual / Family)	\$0/\$0	\$3,000 / \$6,000			
Primary Care Visits   \$5 Copay, first 2 visits, \$25 Copay, visits 3 to 6   Specialist Visits   Specialist Visits   \$50 Copay, up to 4 visits per year   \$50 Copay   \$50 Copa	`	N/A	\$6,000 / \$12,000			
Specialist Visits	PROFESSIONAL SERVICES	Your responsibility is:	Your responsibility is:			
Urgent Care	Primary Care Visits	\$5 Copay, first 2 visits, \$25 Copay, visits 3 to 6	\$5 Copay, first 2 visits, \$25 Copay, visits 3+			
Preventative Services   Covered 100%   Covered 100%   Teledoctor   S0 Copay   \$0 Copay	Specialist Visits	\$50 Copay, up to 4 visits per year	\$50 Copay			
Teledoctor	Urgent Care	\$25 Copay, up to 4 visits per year	\$50 Copay			
Non-Preferred Brand   Pixel Dollar Reimbursement   Debuctible Amount	Preventative Services	Covered 100%	Covered 100%			
X-RAY / LAB	Teledoctor	\$0 Copay	\$0 Copay			
X-ray Services		FIXED DOLLAR REIMBURSEMENT	DEDUCTIBLE AMOUNT			
Laboratory Services   \$500 up to 12 per year   Deductible then 20%	X-RAY / LAB	Plan Will Cover Up To:	Your Responsibility Is:			
Magnetic Resonance Imaging (MRI)   \$1,600 up to 1 per year   Deductible then 20%	X-ray Services	\$1,000 up to 5 per year	Deductible then 20%			
Computerized Tomography (CT) Scan   \$1,500 up to 1 per year   Deductible then 20%	Laboratory Services	\$500 up to 12 per year	Deductible then 20%			
INPATIENT/OUTPATIENT BENEFITS Inpatient Hospital Services, Including Childbirth & MH/SUD  Outpatient Surgery Anesthesia Services \$2,000 up to 1 per year Deductible then 20%  Anesthesia Services \$2,000 up to 1 per year Deductible then 20%  Outpatient Mental Health Benefit S500 up to 24 per year Deductible then 20%  Outpatient Alcohol and Substance Abuse Benefit S500 up to 24 per year Deductible then 20%  Inpatient / Outpatient Doctor Benefit S125 up to 10 per year Deductible then 20%  EMERGENCY ROOM VISIT Plan Will Cover Up to: Treatment of an Accidental Injury S500 up to 2 per year S500 Copay, then Deductible + 20%  Treatment of a Sickness S50 up to 1 per year N/A  PRESCRIPTION DRUGS Your responsibility is: Retail (30 days) Generic S5 Copay S15 Copay S30 Copay Preferred Brand N/A  N/A  NOn-Preferred Brand N/A  PLAN RATES Teammate Weekly Cost Teammate Weekly Cost Teammate & Spouse S46.38 S110.01 S153.69 S159.16 Teammate & Children S56.46 S112.78 S126.46 S131.93	Magnetic Resonance Imaging (MRI)	\$1,600 up to 1 per year	Deductible then 20%			
Inpatient Hospital Services, Including Childbirth & MH/SUD	Computerized Tomography (CT) Scan	\$1,500 up to 1 per year	Deductible then 20%			
MH/SUD         \$500 up to 3 days         Deductible their 20%           Outpatient Surgery         \$2,000 up to 1 per year         Deductible then 20%           Anesthesia Services         \$2,000 up to 1 per year         Deductible then 20%           Outpatient Mental Health Benefit         \$500 up to 24 per year         Deductible then 20%           Outpatient Alcohol and Substance Abuse Benefit         \$500 up to 24 per year         Deductible then 20%           Inpatient / Outpatient Doctor Benefit         \$125 up to 10 per year         Deductible then 20%           EMERGENCY ROOM VISIT         Plan Will Cover Up to:         Plan Will Cover Up to:           Treatment of an Accidental Injury         \$500 up to 2 per year         \$500 Copay, then Deductible + 20%           Treatment of a Sickness         \$50 up to 1 per year         N / A           PRESCRIPTION DRUGS         Your responsibility is:         Retail (30 days)         Mail Order (30 days)           Generic         \$5 Copay         \$15 Copay         \$30 Copay           Preferred Brand         N / A         30%, minimum \$35         30%, minimum \$70           Non-Preferred Brand         N / A         40%, minimum \$70         40%, minimum \$150           PLAN RATES         Teammate Weekly Cost         \$15. 516.99         \$17+           Teammate & Spouse         \$46.38 <td>INPATIENT/OUTPATIENT BENEFITS</td> <td>Plan Will Cover Up to:</td> <td colspan="4">Your responsibility is:</td>	INPATIENT/OUTPATIENT BENEFITS	Plan Will Cover Up to:	Your responsibility is:			
Anesthesia Services \$2,000 up to 1 per year Deductible then 20%  Outpatient Mental Health Benefit \$500 up to 24 per year Deductible then 20%  Outpatient Alcohol and Substance Abuse Benefit \$500 up to 24 per year Deductible then 20%  Inpatient / Outpatient Doctor Benefit \$125 up to 10 per year Deductible then 20%  EMERGENCY ROOM VISIT Plan Will Cover Up to: Plan Will Cover Up to:  Treatment of an Accidental Injury \$500 up to 2 per year \$500 Copay, then Deductible + 20%  Treatment of a Sickness \$50 up to 1 per year N / A  PRESCRIPTION DRUGS Your responsibility is: Retail (30 days) Mail Order (90 days)  Generic \$5 Copay \$15 Copay \$30 Copay  Preferred Brand N / A 30%, minimum \$35 30%, minimum \$70 40%, minimum \$70 Non-Preferred Brand N / A 40%, minimum \$70 40%, minimum \$150 Non-Preferred Brand N / A 40%, minimum \$70 \$150 Non-Preferred Bran		\$500 up to 3 days	Deductible then 20%			
Outpatient Mental Health Benefit         \$500 up to 24 per year         Deductible then 20%           Outpatient Alcohol and Substance Abuse Benefit         \$500 up to 24 per year         Deductible then 20%           Inpatient / Outpatient Doctor Benefit         \$125 up to 10 per year         Deductible then 20%           EMERGENCY ROOM VISIT         Plan Will Cover Up to:         Plan Will Cover Up to:           Treatment of an Accidental Injury         \$500 up to 2 per year         \$500 Copay, then Deductible + 20%           Treatment of a Sickness         \$50 up to 1 per year         N / A           PRESCRIPTION DRUGS         Your responsibility is:         Retail (30 days)         Mail Order (90 days)           Generic         \$5 Copay         \$15 Copay         \$30 Copay           Preferred Brand         N / A         30%, minimum \$35         30%, minimum \$70           NOn-Preferred Brand         N / A         40%, minimum \$70         40%, minimum \$150           PLAN RATES         Teammate Weekly Cost         Payrate: \$15 - \$16.99         \$17+           Teammate Only         \$17.82         \$25.17         \$37.76         \$42.79           Teammate & Spouse         \$46.38         \$140.01         \$153.69         \$159.16           Teammate & Children         \$56.46         \$112.78         \$126.46         \$131.93 </td <td>Outpatient Surgery</td> <td>\$2,000 up to 1 per year</td> <td colspan="4">Deductible then 20%</td>	Outpatient Surgery	\$2,000 up to 1 per year	Deductible then 20%			
Outpatient Alcohol and Substance Abuse Benefit         \$500 up to 24 per year         Deductible then 20%           Inpatient / Outpatient Doctor Benefit         \$125 up to 10 per year         Deductible then 20%           EMERGENCY ROOM VISIT         Plan Will Cover Up to:         Plan Will Cover Up to:           Treatment of an Accidental Injury         \$500 up to 2 per year         \$500 Copay, then Deductible + 20%           Treatment of a Sickness         \$50 up to 1 per year         N / A           PRESCRIPTION DRUGS         Your responsibility is:         Retail (30 days)         Mall Order (90 days)           Generic         \$5 Copay         \$15 Copay         \$30 Copay           Preferred Brand         N / A         30%, minimum \$35         30%, minimum \$70           Non-Preferred Brand         N / A         40%, minimum \$70         40%, minimum \$150           PLAN RATES         Teammate Weekly Cost         Payrate: \$15 - \$14.99 (31 - \$14.99) (31 - \$14.99) (31 - \$14.99) (31 - \$15.16.99) (31 - \$14.99) (31 - \$15.16.99) (31 - \$14.99) (31 - \$15.16.99) (31 - \$14.99) (31 - \$15.16	Anesthesia Services	\$2,000 up to 1 per year	Deductible then 20%			
Inpatient / Outpatient Doctor Benefit	Outpatient Mental Health Benefit	\$500 up to 24 per year	Deductible then 20%			
EMERGENCY ROOM VISIT   Plan Will Cover Up to:   Plan Will Cover Up to:   Treatment of an Accidental Injury   \$500 up to 2 per year   \$500 Copay, then Deductible + 20%	Outpatient Alcohol and Substance Abuse Benefit	\$500 up to 24 per year	Deductible then 20%			
Treatment of an Accidental Injury         \$500 up to 2 per year         \$500 Copay, then Deductible + 20%           Treatment of a Sickness         \$50 up to 1 per year         N / A           PRESCRIPTION DRUGS         Your responsibility is:         Retail (30 days)         Mail Order (90 days)           Generic         \$5 Copay         \$15 Copay         \$30 Copay           Preferred Brand         N / A         30%, minimum \$35         30%, minimum \$70           Non-Preferred Brand         N / A         40%, minimum \$70         40%, minimum \$150           PLAN RATES         Teammate Weekly Cost         Payrate: \$10 - \$14.99         \$15 - \$16.99         \$17+           Teammate Only         \$17.82         \$25.17         \$37.76         \$42.79           Teammate & Spouse         \$46.38         \$140.01         \$153.69         \$159.16           Teammate & Children         \$56.46         \$112.78         \$126.46         \$131.93	Inpatient / Outpatient Doctor Benefit	\$125 up to 10 per year	Deductible then 20%			
Treatment of a Sickness         \$50 up to 1 per year         N / A           PRESCRIPTION DRUGS         Your responsibility is:         Retail (30 days)         Mail Order (90 days)           Generic         \$5 Copay         \$15 Copay         \$30 Copay           Preferred Brand         N / A         30%, minimum \$35         30%, minimum \$70           Non-Preferred Brand         N / A         40%, minimum \$70         40%, minimum \$150           PLAN RATES         Teammate Weekly Cost         Payrate: \$15 - \$16.99         \$150           PLAN RATES         Teammate Weekly Cost         \$25.17         \$37.76         \$42.79           Teammate & Spouse         \$46.38         \$140.01         \$153.69         \$159.16           Teammate & Children         \$56.46         \$112.78         \$126.46         \$131.93	EMERGENCY ROOM VISIT	Plan Will Cover Up to:	Plan Will Cover Up to:			
PRESCRIPTION DRUGS         Your responsibility is:         Retail (30 days)         Mail Order (90 days)           Generic         \$5 Copay         \$15 Copay         \$30 Copay           Preferred Brand         N / A         30%, minimum \$35         30%, minimum \$70           Non-Preferred Brand         N / A         40%, minimum \$70         40%, minimum \$150           PLAN RATES         Teammate Weekly Cost         Payrate: \$15 - \$16.99         \$17+           Teammate Only         \$17.82         \$25.17         \$37.76         \$42.79           Teammate & Spouse         \$46.38         \$140.01         \$153.69         \$159.16           Teammate & Children         \$56.46         \$112.78         \$126.46         \$131.93	Treatment of an Accidental Injury	\$500 up to 2 per year	\$500 Copay, then Deductible + 20%			
Selection   Sele	Treatment of a Sickness	\$50 up to 1 per year	N/A			
Preferred Brand         N / A         30%, minimum \$35         30%, minimum \$70           Non-Preferred Brand         N / A         40%, minimum \$70         40%, minimum \$150           PLAN RATES         Teammate Weekly Cost         Payrate: \$10 - \$14.99         Payrate: \$15 - \$16.99         Payrate: \$17+           Teammate Only         \$17.82         \$25.17         \$37.76         \$42.79           Teammate & Spouse         \$46.38         \$140.01         \$153.69         \$159.16           Teammate & Children         \$56.46         \$112.78         \$126.46         \$131.93	PRESCRIPTION DRUGS	Your responsibility is:		7.77		
N/A   30%, minimum \$35   \$70	Generic	\$5 Copay	\$15 Copay		\$30 Copay	
Plan Rate   Payrate:	Preferred Brand	N / A	30%, minimu	50%, minimum \$35		\$70
Teammate Only \$17.82 \$25.17 \$37.76 \$42.79  Teammate & Spouse \$46.38 \$140.01 \$153.69 \$159.16  Teammate & Children \$56.46 \$112.78 \$126.46 \$131.93	Non-Preferred Brand	N / A	,	ium \$70		\$150
Teammate & Spouse         \$46.38         \$140.01         \$153.69         \$159.16           Teammate & Children         \$56.46         \$112.78         \$126.46         \$131.93	PLAN RATES	Teammate Weekly Cost				
Teammate & Children \$56.46 \$112.78 \$126.46 \$131.93	Teammate Only	\$17.82	\$25.17	\$37.7	6	\$42.79
\$35.10 \$112.10 \$120.10 \$101.00	Teammate & Spouse	\$46.38	\$140.01	\$153.6	69	\$159.16
Family \$80.69 \$258.93 \$272.61 \$278.08	Teammate & Children	\$56.46	\$112.78	\$126.4	16	\$131.93
	Family	\$80.69	\$258.93	\$272.6	31	\$278.08

The benefits outlined here are for IN NETWORK benefits only. You MUST be sure to confirm the provider or facility you choose participates in the network before you visit. The MEC plan does not cover out of network providers or facilities. If you choose to use an out of network provider you will be responsible for the full cost of the service or visit.

## **Finding a Provider**

- Visit <u>umr.com</u> and select "Find a provider"
- Scroll to "UnitedHealthcare Options PPO Network" or "UnitedHealthcare Choice Plus" in the alphabetical list, or type it into the search box
- For medical providers, choose "View Providers"
- For behaviorial health providers, select "Behavioral Health Directory"

For assistance with any benefits questions, claims, and billing inquiries, please call the **Teammate Benefits Line** at: 1-833-236-7463