BENEFITS GUIDE

JANUARY 1, 2025 - DECEMBER 31, 2025

PSHCG
PUBLIC SECTOR HEALTH CARE GROUP
AUTHORITY
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2025

PUBLIC SECTOR HEALTHCARE GROUP AUTHORITY

WELCOME

Thank you for taking the time to learn more about the employee benefits available to you in 2025. Your employer is a member of the Public Sector Health Care Group (PSHCG), an association of like-minded political entities who know the value of employee benefits and more importantly, maintaining your health and income should you become ill or injured. This benefit booklet offers an overview of the key features of the plans. Benefits are more fully described in the formal provisions of the plan documents. If there is a conflict between the highlights and the plan documents, the plan documents govern. If you have questions, please contact Human Resources. We thank you for contributing to our success!

OPEN ENROLLMENT KEY POINTS

It's Open Enrollment time, and that means this is your one opportunity to make your benefit choices for the calendar year, 2025. Outside of a qualifying life event, like marriage or the birth of a child, your benefit selections will remain in place through December 31, 2025. Also, it is important to know that life events only allow you to add or terminate coverage for you or your dependents. They never allow you to change medical insurance plans, if your employer offers a choice. If you do have a life change, please talk with your employer to clear up any questions you have and execute the change within 30 days of the date of your qualifying event.

OPEN ENROLLMENT DATES

Open Enrollment will be held from October 28th through November 18th. Your employer might have specific dates in mind, so look for further communication.

NEW HIRES

You are eligible to join the benefits once you satisfy the new hire waiting period, which is determined by your employer. Contact Human Resources for more information.

WHO IS ELIGIBLE?

Your employer determines who is a benefit eligible employee within your organization. Check with your HR representative to further clarify their full-time status rules.

Eligible dependents include:

- Your legally married spouse, domestic partner or common law partner
- Dependent children up to age 26 *(adopted children and/or stepchildren)*
- Disabled dependent children over the age of 26 *(Doctor verification required)*

QUESTIONS?

Please contact your HR representative for any questions related to open enrollment and benefits.

CARRIER INFORMATION

United Healthcare - Group #0906675 - www.myuhc.com - 800-357-0978
UHC Surest - Group #78800806 - Benefits.Surest.com - 800-357-0978
MetLife - Group #5348811 - www.metlife.com - 800-275-4638
Optum RX - Group #0906675 - www.optumrx.com - 800-356-3477
Optum Employee Assistance Program - 866-374-6061 - Access Code: PSHCG

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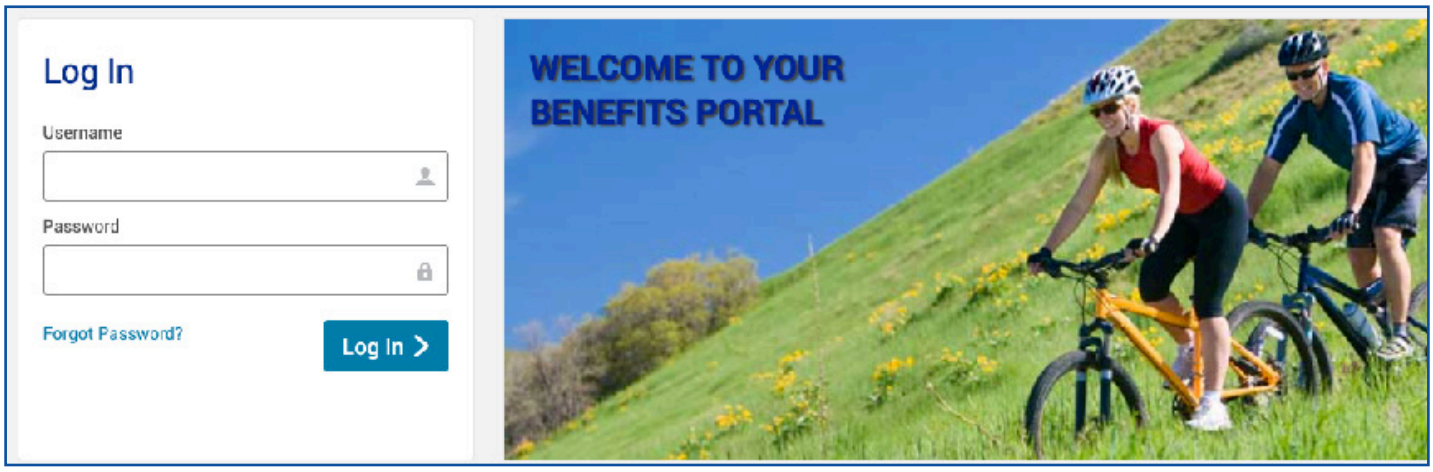
BSWIFT BENEFITS PORTAL

OPEN ENROLLMENT INSTRUCTIONS

To log into the portal visit: clarity.bswift.com



At the log in page enter:

User name - first initial and full last name, your day and year of birth
Example: Ann Smith 05/04/1986= Asmith041986 *(Please note: this is not case-sensitive)*
Password - last 4 digits of your Social Security Number

After logging in you will be asked to create a new password. This will ensure your security to the website. (Please Note: HR does not have access to your new password, they will only be able to reset the password to the last 4 digits of your social security number).

After changing your password you will create Security Questions and Answers.

Once logged into the site as a new hire you will be able to elect benefits and view plan documents for all benefits available to you.

MEDICAL - UNITED HEALTHCARE

CHOICE PLUS PPO PLAN C	
BENEFITS	**IN-NETWORK**
Dr. Office Visit - Primary Care Physician	$0 copay
Specialist Visit	$50 copay
Preventive Care	Plan pays 100% for approved services
Individual Deductible	$3,000
Family Deductible	$6,000
Co-Insurance Percentage	You pay 20% after deductible
Individual Out-of-Pocket Max	$6,500
Family Out-of-Pocket Max	$13,000
Inpatient Hospital	You pay 20% after deductible
Outpatient Services	You pay 20% after deductible
Emergency Room	You pay 20% after deductible
Urgent Care	$0 copay
MRI, CT, PET Scans	$750 copay
Prescription Drug Copays	$5 / $40 / $60 / 25% max $500

The table above is for illustrative purposes only.
See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations, and out-of-network coverage details.

MEDICAL - UNITED HEALTHCARE

CHOICE PLUS PPO PLAN D HSA	
BENEFITS	**IN-NETWORK**
Dr. Office Visit - Primary Care Physician	You pay 0% after deductible
Specialist Visit	You pay 0% after deductible
Preventive Care	Plan pays 100% for approved services
Individual Deductible	$2,500
Family Deductible	$5,000 per family * COMBINED
Co-Insurance Percentage	You pay 0% after deductible
Individual Out-of-Pocket Max	$3,500
Family Out-of-Pocket Max	$7,000 per family *COMBINED
Inpatient Hospital	You pay 0% after deductible
Outpatient Services	You pay 0% after deductible
Emergency Room	You pay 0% after deductible
Urgent Care	You pay 0% after deductible
MRI, CT, PET Scans	You pay 0% after deductible
Prescription Drug Copays	Deductible then $15 / $40 / $70 / 25% max $500

The table above is for illustrative purposes only.
See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations, and out-of-network coverage details.

***Combined Deductible:** For family plans, all out-of-pocket expenses paid by family members for health care services count toward the overall family deductible. Once the total out-of-pocket expenses for the family reach the combined family deductible, the health plan starts covering eligible health care costs for the entire family.

Ex: One family member has $2,500 in expenses, another family member has $2,000 in expenses, another has $500 in expenses. The family COMBINED deductible is then met and after-deductible benefits kick in.

MEDICAL - UNITED HEALTHCARE

CHOICE EPO PLAN F HSA	
BENEFITS	**IN-NETWORK**
This plan covers in network benefits only, with the exception of emergency care.	
Dr. Office Visit - Primary Care Physician	You pay 20% after deductible
Specialist Visit	You pay 20% after deductible
Preventive Care	Plan pays 100% for approved services
Individual Deductible	$4,000
Family Deductible	$6,000
Co-Insurance Percentage	You pay 20% after deductible
Individual Out-of-Pocket Max	$6,000 per INDIVIDUAL
Family Out-of-Pocket Max	$12,000 per family *EMBEDDED
Inpatient Hospital	You pay 20% after deductible
Outpatient Services	You pay 20% after deductible
Emergency Room	You pay 20% after deductible
Urgent Care	You pay 20% after deductible
MRI, CT, PET Scans	You pay 20% after deductible
Prescription Drug Copays	You pay 20% after deductible

The table above is for illustrative purposes only. See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations.

***Embedded Deductible:** With an embedded deductible, an individual family member does not need to meet the entire family deductible before their after-deductible benefits begin. Once that family member meets their individual deductible, their benefits will start. Additionally, any amount paid toward an individual's deductible also counts toward the overall family deductible.

Ex: Once an individual meets their $4,000 deductible, their after-deductible benefits begin. The $4,000 is also credited toward the $6,000 family embedded deductible, leaving a remaining balance of $2,000 to be met by other family members before the full family deductible is satisfied.

MEDICAL - UNITED HEALTHCARE

surest

SURESTB4000	
BENEFITS	**IN-NETWORK**
Dr. Office Visit - Primary Care Physician	$10 -$65
Specialist Visit	$10 -$65
Preventive Care	Plan pays 100% for approved services
Individual Deductible	None
Family Deductible	None
Co-Insurance Percentage	You pay 0% after plan copays
Individual Out-of-Pocket Max	$4,000
Family Out-of-Pocket Max	$8,000
Inpatient Hospital	Up to $2,500
Outpatient Services	Up to $2,500
Emergency Room	$375 copay
Urgent Care	$35 copay
MRI, CT, PET Scans	$75 - $550
Prescription Drug Copays	$5 / $40 / $60 / $200

The table above is for illustrative purposes only.
See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations, and out-of-network coverage details.

MEDICAL - UNITED HEALTHCARE

surest

SURESTD6500	
BENEFITS	**IN-NETWORK**
Dr. Office Visit - Primary Care Physician	$25 - $130
Specialist Visit	$25 - $130
Preventive Care	Plan pays 100% for approved services
Individual Deductible	None
Family Deductible	None
Co-Insurance Percentage	You pay 0% after plan copays
Individual Out-of-Pocket Max	$6,500
Family Out-of-Pocket Max	$13,000
Inpatient Hospital	Up to $3,500
Outpatient Services	Up to $3,500
Emergency Room	$850 copay
Urgent Care	$80 copay
MRI, CT, PET Scans	$150 - $1,050
Prescription Drug Copays	$10 / $90 / $120 / $370

The table above is for illustrative purposes only.
See your United Healthcare summary plan descriptions for a complete explanation of benefits and limitations, and out-of-network coverage details.

surest

Shop for care like you do everything else.

It's nice to know the price for things like groceries and gas before you get them. With the Surest health plan, you can see the price for health care before you use it, too. The Surest plan is designed to show you actual prices (not estimates) and treatment options to help you make decisions about where and how to get care. If you have a life-threatening condition, call 911 or go to the ER. For everything else, check your Surest account to find physician prices, treatment options, and ways to save before you get care.

Go to **Benefits.Surest.com or the Surest app** and search by condition or symptom to find care that fits your health need and budget.

Care options at a glance

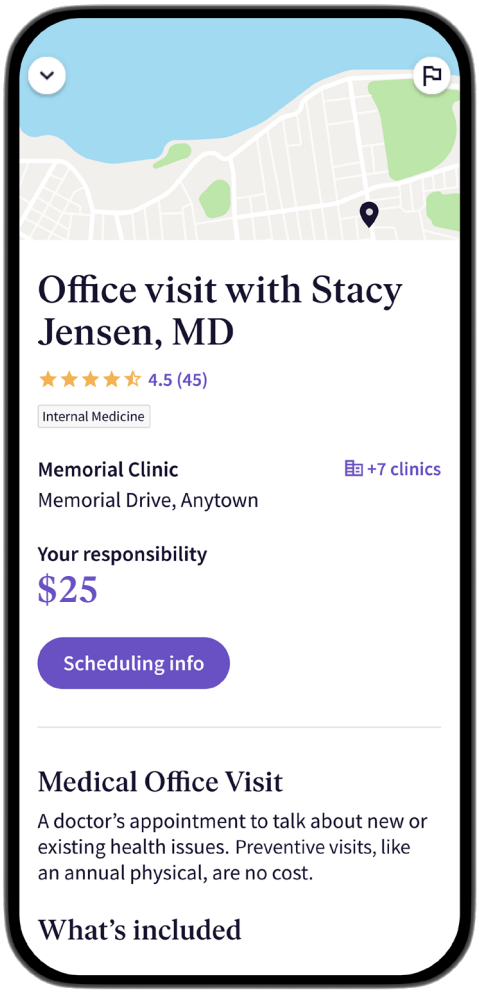
LOW COST

HIGH COST

Virtual care	See a physician for acute, urgent, primary, mental, or specialty needs. Many virtual care providers are available 24/7. You can get care where and when it's most convenient for you.
Primary care	Care from a physician who may know you best, in-office or telehealth visit
Urgent care	Serious conditions that aren't generally life-threatening
Emergency room	Life- and limb-threatening emergencies

surest

See prices and find care from the palm of your hand.



Illustrative example only. Costs and coverage may vary.

Once you have an account, you can shop for care and find ways to save time and money, especially when you use virtual care. See things like:

- Copay—your price for a visit, treatment, or procedure
- Location information and scheduling details
- What's included in a visit

Need help finding care?

Member Services is available online via chat and email or by calling the number on the back of your Surest member ID card.

Go to **Benefits.Surest.com or download the Surest app** to create a Surest account today.

You've got questions. We've got answers.

The **Surest health plan** puts you in the driver's seat so you can search and find the care you need, at prices you can see. When you have questions or need support along the way, our Surest Member Services team is just a click or call away.

Get the free Surest app for help at your fingertips.

GET IT ON Google Play

Available on the App Store

From the Surest app or Benefits.Surest.com

Click "Help" from the purple navigation bar.
Email us to get a response within 24 hours.

From your phone

Call 866-683-6440 to speak with a Surest Member Services team member. Available Monday – Friday from 6 am – 9 pm CT.

Clinical advocates

Clinical Advocacy team can help. Our clinical advocates can offer guidance on providers, locations, and treatment options to support all types of care needs — from family planning and physical therapy to cancer treatment and gender affirming support.

To get in touch, call Surest Member Services at 866-683-6440 and ask to speak with a clinical advocate.

Language support

Surest Member Services offers support to members in English and Spanish, as well as 240 other languages via an interpretation service. Call 866-683-6440 and ask to be connected with language support.

surest™
A UnitedHealthcare Company

UNITED HEALTHCARE PROVIDER NETWORKS

Choice Plus Network: (PPO Plans C, D, F and all Surest plans)

- National network available in all 50 states
- In and out-of-network coverage
- No referral needed to see a specialist (some prior authorizations are required, such as hospital stays and imaging)
- Search for a provider at www.whyuhc.com/choiceplus

PREVENTIVE CARE GUIDELINES

Under the Affordable Care Act (ACA), you can get certain preventive health care services, covered at 100 percent, without any cost to you. Just obtain your preventive care from a health plan network provider. Diagnostic (non-preventive) services are also covered, but you may have to pay a copayment, coinsurance or deductible.

Preventive care guidelines for children:

- Age-appropriate well-child examination
- Anemia screening
- Cholesterol screening for children 24 months and older
- Metabolic screening panel for newborns
- Age-appropriate immunizations
- Vision screening by primary care physician
- Oral health risk assessment by primary care physician
- Fluoride application
- Hearing screening by primary care physician
- Autism and Developmental screening for children under age 3
- Counseling on the harmful effects of smoking and illicit use of drugs
- Counseling for children on promoting improvements in weight
- Screening certain children at high risk for sexually transmitted diseases, lead, depression and tuberculosis

Preventive care guidelines for adults:

- Wellness Examinations
- Well-Women Visits—including routine prenatal visits
- Abdominal Aortic Aneurysm Screening—for age 65-75 years who have ever smoked
- Alcohol Screening and Brief Counseling—screening during wellness examination
- Bacteriuria Screening—during pregnancy
- Blood Pressure Screening—at each wellness examination
- Breastfeeding Primary Care Interventions, Counseling, Support and Supplies—during pregnancy and after birth. Includes personal use of an electric breast pump.
- Cervical Cancer Screening (Pap Smear)—women age 21-65 years old
- Chemoprevention of Breast Cancer, Counseling—for women at high risk of breast cancer
- Chlamydia and Gonorrhea Infection Screening—for sexually active women age 24 and younger
- Cholesterol Screening—for age 40-75 years
- Colorectal Cancer Screening—for age 50-75 years
- Contraceptive Methods—FDA-approved methods of contraception for women
- Depression Screening—for all adults, in a primary care setting
- Diabetes Screening—for age 40-70 who are overweight or obese or for those of any age with a history of gestational diabetes
- Falls Prevention Counseling—during wellness examination, for community-dwelling older adults
- Genetic Counseling and Evaluation for BRCA Testing & BRCA Lab—lab testing requires prior authorization
- Gestational Diabetes Mellitus Screening—during pregnancy
- Healthy Diet Behavioral Counseling—for persons with cardiovascular disease risk factors
- Hepatitis B Virus Infection Screening—for persons at high risk
- Hepatitis C Virus Infection Screening—one-time screening for adults born between 1945-1965 or high risk
- Human Immunodeficiency Virus (HIV) Screening—for all adults
- Human Papillomavirus DNA Testing—for women age 30-65
- Immunizations—FDA approved and have explicit ACIP recommendations for routine use
- Intimate Partner Violence, Interpersonal and Domestic Violence, Counseling and Screening—during wellness examination
- Latent Tuberculosis Infection Screening—for persons at increased risk
- Lung Cancer Screening with Low-Dose CT Scan—for age 55-80 years with at least a 30 pack-year history (prior authorization)
- Mammography Screening
- Obesity Screening and Counseling—at each wellness examination
- Osteoporosis Screening—women age 65 and older, and younger women at increased risk
- Rh Incompatibility Screening—during pregnancy
- Sexually Transmitted Infections, Behavioral Counseling to Prevent—behavioral counseling for adults who are sexually active or otherwise at increased risk, in primary care setting
- Skin Cancer, Behavioral Counseling to Prevent—at each wellness examination, for young adults up to age 24 years
- Syphilis Screening—for adults at increased risk
- Tobacco Cessation, Screening, Behavioral Counseling—screening, and behavioral counseling for adults who smoke

For more information about preventive guidelines for your age and gender, visit uhc.com/preventivecare

UNITED HEALTHCARE MOBILE APP

A health plan that's always with you

Digital tools to keep you connected

Get the most out of your benefits

Register for your personalized website on myuhc.com® and download the UnitedHealthcare® app. These digital tools are designed to help you understand your benefits and make informed decisions about your care.

- Find care and compare costs for providers and services in your network
- Check your plan balances, view your claims and access your health plan ID card
- Access wellness programs and view clinical recommendations
- 24/7 Virtual Visits – Connect with providers by phone or video* to discuss common medical conditions and get prescriptions,** if needed
- View your health care financial account(s) such as HSA, FSA or HRA
- Compare prescription costs and order refills

Register today

Scan the QR code or go to **myuhc.com** and click **Register Now**

See next page for registration steps

Download the app
Available for iPhone and Android

*Data rates may apply.
**Certain prescriptions may not be available, and other restrictions may apply.

continued

United Healthcare

VIRTUAL MEDICINE - UHC

24/7 virtual care. Zero dollars.

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

Another way to get care

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

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

Looking for smart savings?

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

$0

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

continued

UnitedHealthcare

VIRTUAL MEDICINE - UHC

Your 24/7 Virtual Visits questions answered

Question	Answer
Are 24/7 Virtual Visits covered by my health plan?	Yes. 24/7 Virtual Visits are covered by your UnitedHealthcare plan when you use one of the provider groups in our 24/7 Virtual Visits network.
How much does it cost?	24/7 Virtual Visits typically cost $50* or less for UnitedHealthcare members. The actual amount varies by plan and you should check your plan documents to determine your specific out-of-pocket costs.
Do they count toward my deductible?	Yes. Any out-of-pocket costs for your 24/7 Virtual Visit count toward your deductible and yearly out-of-pocket limit.
When and how do I pay?	You pay at the time of the 24/7 Virtual Visit with a credit, debit or health savings account (HSA) card.
I paid for my 24/7 Virtual Visit when I received care, and then I got a reimbursement for that amount from the provider. Why is that?	There are certain benefit plans where UnitedHealthcare automatically pays providers for a member's visit. Because this payment is made after the visit and providers don't know your benefit plan before you visit, you may be required to pay at the time of the visit and then be reimbursed by UnitedHealthcare. For health reimbursement accounts (HRAs), when offered, the platform is set up to reimburse you directly when funds are available. You can check for additional claim payment information by visiting myuhc.com®.
Am I required to have a primary care physician (PCP) in order to have a 24/7 Virtual Visit?	No. You don't need a PCP or even a referral to use a 24/7 Virtual Visit.
Where can I find out what providers are in the 24/7 Virtual Visits network and how do I access them?	You can find providers by signing in to myuhc.com/virtualvisits or using the UnitedHealthcare® app on your mobile device.** You can start a 24/7 Virtual Visit directly from either the website or app.
What happens once I reach the 24/7 Virtual Visit provider group's website?	The first time you use a 24/7 Virtual Visit provider you will set up an account with that provider group. This includes sharing some medical history information, pharmacy preference and insurance information.

*The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

**Data rates may apply.

continued

United Healthcare

VIRTUAL MEDICINE - UHC

Question	Answer
How long is the wait once I am at the provider group's site?	24/7 Virtual Visits provider groups are generally expected to deliver care within 30 minutes of you submitting a request for a visit. However, the wait may be longer.
What happens during an actual 24/7 Virtual Visit?	At the start of your visit, you will be asked some questions about your current medical concern. From there, you will be connected using secure live audio and video technology to a doctor licensed to deliver care in the state that you are in at the time of your visit. You and the doctor will discuss your medical issue, and the doctor may even write a prescription* for you if appropriate.
If I get a prescription during my 24/7 Virtual Visit, how does it get to my local pharmacy?	Providers submit prescriptions to the pharmacy of your choice electronically. The costs of your prescription will be the same as if you got it from an in-person visit.
Some provider groups list other services like nutrition counseling, lactation services, therapy, etc. Are these covered under my 24/7 Virtual Visits benefit?	Not at this time. Because they aren't covered, if you choose to use them you will be responsible for the full cost of the service and they won't count toward your deductible or out-of-pocket limit.
Will my 24/7 Virtual Visit information be shared with my PCP?	If you provide your PCP information to the 24/7 Virtual Visit provider, your information will be sent to your PCP after your visit. If you don't provide your PCP information to the 24/7 Virtual Visit provider you may need to request the records to share them with your PCP or another care provider.
How safe is the information being shared during a 24/7 Virtual Visit appointment?	24/7 Virtual Visits providers are covered entities under HIPAA and its regulations. These providers have legal requirements to protect and secure confidential patient information. Additional information regarding security and privacy is available at each provider group's website.
Can my child or underage dependent use 24/7 Virtual Visits?	Yes. In general, a parent or legal guardian must be present when the 24/7 Virtual Visit is conducted with a child or underage dependent who is covered by your plan.
Are additional languages (besides English) supported by 24/7 Virtual Visits provider groups?	Yes. Specifics vary by provider group. All provider groups offer some Spanish-speaking physicians, although not in all states. Additional information is available at each provider group's website.
What should I do if I have the UnitedHealthcare app downloaded on my phone but I can't see the 24/7 Virtual Visits content?	You might have to update the app to the latest version.

Access 24/7 Virtual Visits on **myuhc.com** to learn more

United Healthcare

*Certain prescriptions may not be available, and other restrictions may apply.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

VISIT THE UNITED HEALTHCARE MOBILE APP

Good care starts with good information.

Remembering the medications you've been prescribed, procedures you've had and conditions you've been treated for isn't always easy. With the new Individual Health Record feature on **myuhc.com®** and the UnitedHealthcare® app, you don't have to.

Discussing your health history just got easier.

Your Individual Health Record puts over a year's worth of history—from all of your providers*—in the palm of your hand. So now, each time you visit a doctor, you can bring it along to help ensure they have a better picture of your overall health.

One place provides access to your:

- Allergies
- Care Team
- Conditions
- Immunizations
- Prescriptions
- Procedures

View your health history on the spot:

- **Go to myuhc.com > Account/Profile > Individual Health Record.**
- **Go to UnitedHealthcare app > Menu Icon > Individual Health Record.**

*Individual Health Record only applies to care you've received as a UnitedHealthcare member, so newer members will have less history.

Your Individual Health Record only has information on care you've received as a UnitedHealthcare member during a certain timeframe. Information in the Individual Health Record is not a substitute for medical or behavioral health care advice. If you have questions about information in your Individual Health Record, please talk with your doctor or call the IHR Dedicated Service Team toll-free at 1-844-585-1471.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

Facebook.com/UnitedHealthcare **Twitter**.com/UHC **Instagram**.com/UnitedHealthcare **YouTube**.com/UnitedHealthcare

UnitedHealthcare®

REAL APPEAL - WEIGHT MANAGEMENT PROGRAM

Healthier habits, healthier lifestyle

Take small steps for lasting change with Real Appeal®, an online weight management support program.

Get healthier, at no additional cost to you

Real Appeal on Rally Coach™ is a proven weight management program designed to help you get healthier and stay healthier. It's available to you and eligible family members at no additional cost as part of your benefits.

Take small steps toward healthier habits

Set achievable nutrition, exercise and weight management goals that keep you motivated to create lasting change. Track your progress from your daily dashboard, too.

Support and community along the way

Feel supported with personalized messages, online group sessions led by coaches and a caring community of members.

Get a Success Kit delivered right to your door.

Make the most of tools and resources like weight and food scales, a portion plate and more. Your Success Kit is delivered after you attend your first live group session.

Join today at enroll.realappeal.com or scan this code

United Healthcare | Real Appeal®

ONE PASS SELECT - FITNESS MEMBERSHIP

Flexible, accessible health options for employees

Half of U.S. consumers report wellness as a top priority in their daily lives.[1] One Pass Select™ is designed to help make it easier for your employees to prioritize their health and wellness through a lower-cost, extensive nationwide gym network—including digital fitness. Best of all, your employees have the freedom to choose the option that fits their needs and lifestyle.

See the benefits of One Pass Select:

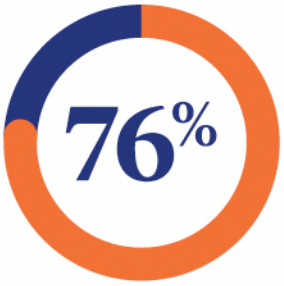
Potential increased productivity
Studies show that healthier employees are typically more productive.[2]

No cost to you, low cost to your employees
Allows you to offer various fitness pricing options and competitive, flexible health options so employees can choose what's best for them.

A simple digital experience
Easy access through UnitedHealthcare Rewards on the **UnitedHealthcare® app** or **myuhc.com®** to browse membership options, a fitness directory and more.

UHC Rewards integration
Employees can redeem UHC Rewards dollars to use toward a One Pass Select subscription.

average retail gym membership savings with One Pass Select[3]



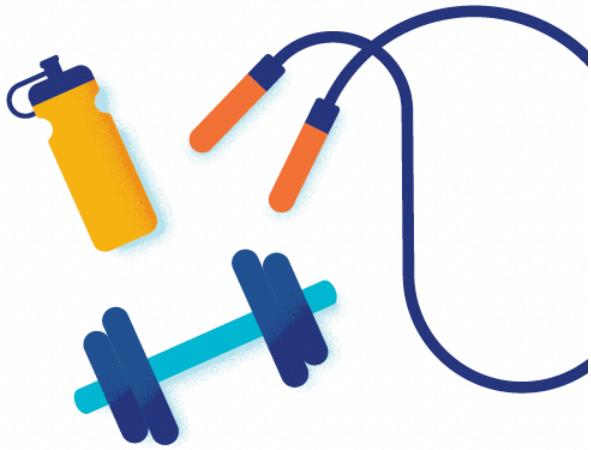
of employees who signed up for One Pass Select were actively engaged in the program[4]

ONE PASS SELECT - FITNESS MEMBERSHIP

More advantages for employees

One Pass Select offers employees various membership tiers to choose from based on their unique fitness goals—along with additional benefits, including:

- No long-term contracts or annual gym registration fees
- Flexible fitness options with the ability to change tiers monthly
- Multi-location access with no waiting period
- The ability to add family members (ages 18+)



Membership options for employees

Category	Digital	Classic	Standard	Premium	Elite
Monthly fee	$10	$29	$64	$99	$144
One-time enrollment fee	$10	$29	$29	$29	$29
Gym network size		11,000+	13,000+	16,000+	18,000+
Premium network			✓	✓	✓
Multi-location access		✓	✓	✓	✓
Digital classes	23,000+	23,000+	23,000+	23,000+	23,000+
On-demand	✓	✓	✓	✓	✓
Livestreaming	✓	✓	✓	✓	✓
Workout builder	✓	✓	✓	✓	✓
Family memberships*	✓	✓	✓	✓	✓
Upgrade/downgrade	✓	✓	✓	✓	✓
Cancel within 30 days	✓	✓	✓	✓	✓

*10% discount

Learn more

Contact your UnitedHealthcare representative

United Healthcare

[1] McKinsey & Company. Still feeling good: The US wellness market continues to boom. mckinsey.com/industries/consumer-packaged-goods/our-insights/still-feeling-good-the-us-wellness-market-continues-to-boom. Sept. 12, 2022.

[2] Centers for Disease Control and Prevention. Increase Productivity. cdc.gov/workplacehealthpromotion/model/control-costs/benefits/productivity.html. Accessed February 2023.

[3] One Pass Select Internal Analytics/Book of Business, 2022.

[4] One Pass Select Utilization Report, 2023.

One Pass Select is a voluntary program. For fully insured participants (not available in HI, KS, VT and Puerto Rico), it features a subscription-based nationwide gym network and digital fitness. For self-funded participants nationally, it features a subscription-based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable. One Pass Select is a program offered by Optum. Subscription costs are payable to Optum.

UnitedHealthcare Rewards is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker, certain credits and/or rewards and/or purchasing an activity tracker with earnings may have tax implications. You should consult with an appropriate tax professional to determine if you have any tax obligations under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to a health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-866-230-2505 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Components subject to change. This program is not available for fully insured members in Hawaii, Vermont and Puerto Rico nor available to level funded members in District of Columbia, Hawaii, Vermont and Puerto Rico.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Insurance coverage is provided by All Savers Insurance Company (for FL, GA, OH, UT and VA), by UnitedHealthcare Insurance Company of IL (for IL), by United Healthcare of Kentucky, Ltd. (for KY), or by UnitedHealthcare Insurance Company (for AL, AR, AZ, CO, DC, GA, IA, ID, IN, KS, LA, MI, MN, MO, MS, NC, NE, NH, NV, OK, PA, SC, SD, TN, TX, UT, VA and WV). These policies have exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or the insuring company. Administrative services provided by Bind Benefits, Inc. d/b/a Surest, its affiliate United HealthCare Services, Inc., or by Bind Benefits, Inc. d/b/a Surest Administrators Services, in CA.

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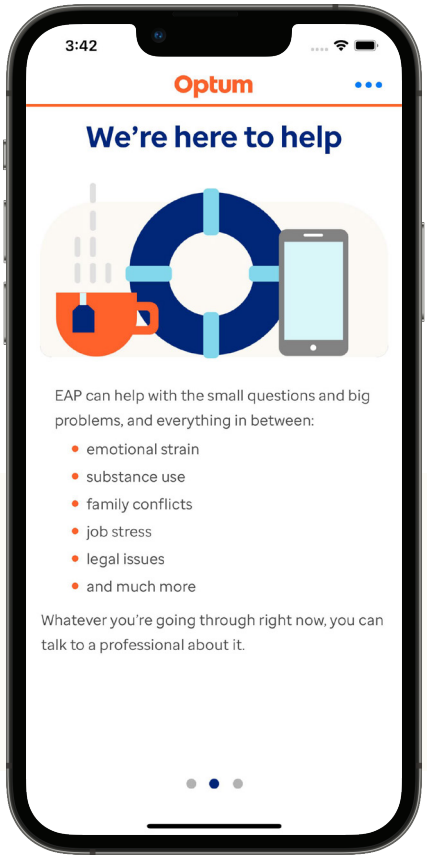
- Talk with an EAP specialist
- Get 4 no-cost counseling sessions per issue, per year
- Find a provider and schedule an appointment
- Access videos and articles about anxiety, caregiving, parenting, relationships, depression and more



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DENTAL - METLIFE

Benefit Summary	
Calendar Year Deductible	$50 per individual / max $150 per family
Deductible Applies to	Type II & III
Dental Calendar Year Maximum	$1,500 per individual in your family
Orthodontia Lifetime Maximum	$1,500 for children up to age 19
Benefit Summary	
Type I - Diagnostic & Preventive	100%
Type II - Basic Services	80%
Type III - Major Services	50%
Type IV - Orthodontic Services	50%
Endodontics / Periodontics	80%
Benefit Summary	
Waiting Period	Waiting periods only apply for late entrants *(members who do not join the plan at their initial enrollment opportunity)*

The table above shows the plan details. Please refer to your plan descriptions for a full list of covered services, limitations, and out-of-network coverage.

Features of the PDP Plus Dental Plan:

- Use any dentist (keep in mind, your greatest savings will be with dentists participating in the MetLife PDP Plus network)
- You pay a coinsurance for services
- Preventive cleanings are covered at 100% and may be scheduled every six months
- Orthodontia is covered for dependent children up to age 19

Search for a Dentist Online:

You can search for a dentist online at www.metlife.com/dental. Click on "Find a dentist" on the right-hand side of your screen and follow the prompts on the next screen.

Provider networks change, so it is always a good idea to call and confirm your dentist's participation in the network.

ID Cards: MetLife **will not** send you an ID card. If you need an ID card, you can request one online. Go to www.metlife.com/dental and log in to your account.

VISION - METLIFE | VSP NETWORK

Key Points Summary	
Eye Exam	$10 copay
Prescription Glasses: Lenses	$10 copay
Prescription Glasses: Frames	$150 retail allowance +20% off
Contact Lenses	$150 allowance
Benefit Frequency	
Eye Exam	Every 12 months
Prescription Glasses: Lenses	Every 12 months
Prescription Glasses: Frames	Every 24 months
Contact Lenses	Every 12 months in lieu of glasses
Network Discounts	
Laser Vision Correction	15% Savings
Prescription Glasses	20% Savings
Contact Lenses	15% off evaluation

Please refer to your plan description for full details and out-of-network benefits.

Need to find an eye doctor in the VSP Network?

For a complete list of providers near you, use the VSP Provider Locator on www.vsp.com/eye-doctor. You may also call MetLife at 1-855-MET-EYE-1.

Using your vision benefits:

You **will not** receive a MetLife ID card. When you schedule your appointment, simply tell them you have VSP for your vision benefits. That's all you need to do!

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is an account funded to help you save for future medical expenses. There are certain advantages to putting money into these accounts, including favorable tax treatment.

WHO CAN HAVE AN HSA?

Any adult can have an HSA if you:

- Have coverage under an HSA-qualified, High Deductible Health Plan (HDHP)
- Are not enrolled in Medicare or another health plan
- Cannot be claimed as a dependent on someone else's tax return

Contributions to your HSA can be made by you, your employer, or both. However, the combined contributions are limited annually. If you make a contribution, you can deduct the contribution (even if you do not itemize deductions) when completing your federal income tax return. Alternatively, some employers will allow you to make your HSA contributions through pre-tax payroll deductions.

Contributions to the account must stop once you are enrolled in Medicare or another health plan that is not a qualified High Deductible Health Plan (HDHP). However, you can still use your HSA funds to pay for medical expenses tax-free.

2025 ANNUAL HSA CONTRIBUTION LIMITS

You can make contributions to your HSA each year that you are eligible. The IRS contribution limits include both employee and employer contributions and tax penalties may apply if you over contribute. Visit www.irs.gov/publications/p969 for more information regarding HSA contributions.

- Single coverage: $4,300
- Family coverage: $8,550

Individuals ages 55 and older can make additional "catch-up" contributions up to $1,000 annually.

USING YOUR HSA

You can use money in your HSA to pay for any qualified healthcare expense permitted under federal tax law. This includes most medical care services, dental, and vision care. Money contributed to an HSA is portable. If you leave employment, the account is yours to keep.

FLEXIBLE SPENDING ACCOUNT

OPTIONAL FLEXIBLE SPENDING ACCOUNT (FSA)

- Healthcare FSA ..... $3,300 annual contribution maximum
- Dependent Care FSA..... $5,000 per single or married filing Joint returns ($2,500 for married filing separate return)

Employees who choose to participate in the FSA must enroll every year.

A Flexible Spending Account (FSA) is a tax-advantaged financial account that allows you to set aside pre-tax dollars for certain out-of-pocket health expenses. Here are some key points:

- Pre-Tax Contributions: Employees contribute a portion of their salary before taxes are deducted, reducing their taxable income.

- Qualified Expenses: Funds can be used for a variety of eligible medical expenses, such as copayments, prescription medications, dental and vision care, and some over-the-counter products.

- Use-it-or-Lose-it Rule: FSAs typically operate under a use-it-or-lose-it policy, meaning funds must be used by the end of the plan year. Your plan may include a rollover feature. Check your specific plan details for more information.

- No Portability: FSAs are not portable; they are tied to your employer. If you change jobs, you generally lose any unused funds.

OCHS - EMPLOYER PAID BASIC LIFE AND AD&D

Life insurance provides financial security for the people who depend on you. Your employer provides a Basic Term Life and AD&D policy for you at no cost. This policy includes an enhanced benefit for Public Safety Officers. View the Bswift Benefits Portal for more information.

BENEFIT AMOUNT	1x Salary
BASIC LIFE AGE REDUCTIONS	
AGE	REDUCES TO
65	65%
70	40%
75	20%

Ochs

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

SPECIAL ENROLLMENT

Loss of Other Coverage

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

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must apply within 30 days from the date of this event.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

CHIP

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office at www.insurekidsnow.gov or dial toll free 1-877-KIDSNOW to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan -- as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

BREAK TIME FOR NURSING MOTHERS UNDER THE FLSA

Time and Location of Breaks

Employers are required to provide a reasonable amount of break time to express milk as frequently as needed by the nursing mother. The frequency of breaks needed to express milk as well as the duration of each break will likely vary.

A bathroom, even if private, is not a permissible location under the Act. The location provided must be functional as a space for expressing breast milk. If the space is not dedicated to the nursing mother's use, it must be available when needed in order to meet the statutory requirement. A space temporarily available when needed by the nursing mother is sufficient, provided that the space is shielded from view, and free from any intrusion from co-workers and the public.

Coverage and Compensation

Only employees who are not exempt from section 7, which includes the FLSA's overtime pay requirements, are entitled to breaks to express milk. While employers are not required under the FLSA to provide breaks to nursing mothers who are exempt from the requirements of Section 7, they may be obligated to provide such breaks under State Law.

Employers with fewer than 50 employees are not subject to the FLSA break time requirement if compliance with the provision would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business. All employees who work for the covered employer, regardless of work site, are counted when determining whether this exemption may apply.

Employers are not required under the FLSA to compensate nursing mothers for breaks taken for the purpose of expressing milk. However, where employers already provide compensated breaks, an employee who uses that break time to express milk must be compensated in the same way that other employees are compensated for break time. In addition, the FLSA's general requirement that the employee must be completely relieved from duty or else the time must be compensated as work time applies.

NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT OF 1996

The group health coverage provided by Public Sector Health Care Group complies with the Newborns' and Mothers' Health Protection Act of 1996.

Under this law group health plans and health insurance insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 ours (or 96 hours).

WOMEN'S HEALTH & CANCER RIGHTS ACT

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas

Health plans must provide coverage of mastectomy-related benefits in a manner determined in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan. Therefore, deductibles and coinsurance apply.

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

- Your hours of employment are reduced
- Your employment ends of any reason other than your gross misconduct

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his or her gross misconduct
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following events:

- The parent-employee dies
- The parent-employee's hours of employment are reduced
- The parent-employee become entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated
- The child stops being eligible for coverage under the plan as a "dependent child"

When is COBRA Continuation Available?
The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare Benefits (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. The continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries under the Plan, including special enrollment rights.

How long will continuation coverage last?
In the case of a loss of coverage due to the end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA continued coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to qualified beneficiaries.

Can you extend the length of an 18 month period of continuation coverage?
If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Human Resources of a disability or second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability: An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the plan of that fact within 30 days after SSA's determination.

Second Qualifying Event: An 18-month extension will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both, or a dependent child's ceasing to be eligible for coverage as a depended under the Plan). These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event has not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Loss of Eligibility for COBRA Continuation Coverage
Continuation coverage will be terminated before the end of the maximum period if any of the following occur:

- Any required premium is not paid in full on time
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (note: there are limitation on plans' imposing a pre-existing condition exclusion and such exclusion with become prohibited beginning in 2014 under the Affordable Care Act)
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage
- The employer ceases to provide any group health plan for its employees

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant of beneficiary not receiving continuation coverage (such as fraud).

How do you elect COBRA Continuation Coverage?
To elect continuation coverage, you must complete an election form and return it to Human Resources. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. The employee can elect continuation coverage on behalf of a qualified spouse. A parent, the employee or his or her spouse may elect to continue coverage on behalf of any dependent children. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Public Sector Health Care Group has determined the United medical plans, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

HIPAA BASICS - YOUR RIGHT TO PRIVACY

In April 2003, the final regulations that place restrictions on how personally identifiable health information (PHI) may be used and disclosed by certain organizations became effective.

These regulations (the Privacy Rules) implement the privacy requirements contained within the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While some states have laws that protect health information, the HIPAA Privacy Rules establish a uniform, minimum level of privacy protections for all health information. In summary, the HIPAA Privacy Rules:

- Set limits on how health information may be used and disclosed
- Require that individuals be told how their health information will be used and disclosed
- Provide individuals with a right to access, amend or copy their medical records
- Give individuals a right to receive an accounting of disclosures, to request special restrictions, and to receive confidential communications
- Impose fines where the requirements contained within the regulations are not met

PATIENT PROTECTION MODEL

Health insurance companies generally require the designation of a primary care provider for services and claims to be covered. You have the right to designate any primary care provider who participates in your selected plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

If you do not choose a primary care physician upon enrolling in a health insurance plan, the insurance company may randomly designate one for you. Some insurance plans will not cover any claims or services if you see a primary care physician or specialist that is not assigned to you and the correct referral process followed.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your group administrator.

If you're nearing retirement age, or are over 65 and still working, you may have questions about Medicare.

WHAT IS MEDICARE?

Medicare is health insurance for people are age 65 or older, under 65 with certain disabilities, or any age with End-stage Renal Disease (permanent kidney failure).

Types of Medicare

There are four types of Medicare.

Medicare Part A helps cover impatient care in hospitals, skilled nursing facilities, and hospice and home health care. Generally, there is no monthly premium if you qualify and paid Medicare taxes while working.

Medicare Part B helps cover medical services like doctors' services, outpatient care and other medically necessary services that Part A doesn't cover. You need to enroll in Medicare Part B and pay a monthly premium determined by your income, along with a deductible.

Many people also purchase a supplemental insurance policy, such as a Medigap plan, to handle any Part A and B coverage gaps.

Medicare Advantage Plans, also known as Medicare Part C, are combination plans managed by private insurance companies approved by Medicare. They typically are a combination of Part A, Part B and sometimes Part D coverage, but must cover medically necessary services. These plans have discretion to assign their own copays, deductibles and coinsurance.

Medicare Part D is prescription drug coverage and is available to everyone with Medicare. It is a separate plan provided by private Medicare-approved companies, and you must pay a monthly premium.

Getting Started

Medicare sends you a questionnaire about three months before you're entitled to Medicare coverage. Your answers to these questions, including whether you have group health insurance through an employer or family member, help Medicare set up your file and make sure your claims are paid correctly.

Coordination of Coverage

If you have Medicare and another type of insurance, the question of who should pay or who should pay first can be tricky. For example, generally a group health plan would pay before Medicare, but there are several exceptions. Visit www.medicare.gov for additional information.

IMPORTANT INFORMATION ABOUT YOUR INSURANCE RIGHTS

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care. For example, this can happen during an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency Services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for the post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles, that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact: Department of Health and Human Services at 1-800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

This summary of benefits is not intended to be a complete description of the terms and insurance benefit plans. Please refer to the plan document(s) for a complete description. Each plan is governed in all respects by the terms of its legal plan document, rather than by this or any other summary of the insurance benefits provided by the plan. In the event of any conflict between a summary of the plan and the official document, the official document will prevail.

PUBLIC SECTOR HEALTHCARE GROUP AUTHORITY

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