Unified Government of Wyandotte County/Kansas City, Kansas
701 North Seventh Street, Ste. 646,Kansas City, Kansas 66101
(913) 573-5660

Health Insurance Premiums

January - December 2022

United Health Care

Non-union, AFSCME, FOP 40, UFCW, IBEW, SEIU and Teamsters employees

Plan Type	Coverage Type	Unified Government Contribution	Employee Base Annual Salary	Employee Monthly Premium	Employee Cost per Pay Check
Traditional	Employee Only	$833.97	$30,000 and below	$12.36	$6.18
			$30,001 - $60,000	$24.74	$12.37
			$60,001 and over	$37.10	$18.55
	Family	$1,986.84	$30,000 and below	$401.10	$200.55
			$30,001 - $60,000	$413.48	$206.74
			$60,001 and over	$425.84	$212.92
HDHP with H.S.A	Employee Only	$750.55	$30,000 and below	$12.36	$6.18
			$30,001 - $60,000	$24.74	$12.37
			$60,001 and over	$37.10	$18.55
	Family	$1,762.54	$30,000 and below	$353.70	$176.85
			$30,001 - $60,000	$366.06	$183.03
			$60,001 and over	$378.44	$189.22

LiUNA-PSEU employees

Plan Type	Coverage Type	Unified Government Contribution	Employee Base Annual Salary	Employee Monthly Premium	Employee Cost per Pay Check
Traditional	Employee Only	$833.97	$60,00 and below	$24.74	$12.37
			$60,001 and over	$37.10	$18.55
	Family	$1,986.84	$60,00 and below	$413.48	$206.74
			$60,001 and over	$425.84	$212.92
HDHP with H.S.A	Employee Only	$750.55	$30,001 - $60,000	$24.74	$12.37
			$60,01 and over	$37.10	$18.55
	Family	$1,762.54	$30,001 - $60,000	$366.06	$183.03
			$60,001 and over	$378.44	$189.22

FOP4 employees

Plan Type	Coverage Type	Unified Government Contribution	Employee Monthly Premium	Employee Cost per Pay Check
Traditional	Employee Only	$833.97	$37.10	$18.55
	Family	$1,986.84	$425.84	$212.92
HDHP with H.S.A	Employee Only	$750.55	$37.10	$18.55
	Family	$1,762.54	$378.44	$189.22

Unified Government of Wyandotte County/Kansas City, Kansas
701 North Seventh Street, Ste. 646,Kansas City, Kansas 66101
(913) 573-5660

Health Insurance Premiums

January - December 2022

United Healthcare

IAFF64 employees

Plan Type	Coverage Type	Unified Government Contribution	Employee Monthly Premium	Employee Cost per Pay Check
Traditional	Employee Only	$833.97	$30.00	$15.00
	Family	$1,986.84	$425.84	$212.92
HDHP with H.S.A	Employee Only	$750.55	$30.00	$15.00
	Family	$1,762.54	$378.44	$189.22

Delta Dental

	Unified Government Contribution	Employee Monthly Premium	Employee Cost per Pay Check
Employee Only	$30.36	$0.00	$0.00
Family Coverage	$71.32	$13.68	$6.84

Eyemed Vision Care

	Unified Government Contribution	Employee Monthly Premium	Employee Cost per Pay Check
Employee Only	$4.33	$0.00	$0.00
Family Coverage	$9.35	$1.68	$0.84

If you have questions, call Human Resources at 913-573-5660 or email benefits@wycokck.org

2022 Plan Coverage Options

Type of Coverage		H.S.A.	Traditional
Network Deductible	Single	$1,400	$700
	Family	$2,800	$1,400
Co-Insurance (what the plan pays after deductible)		100%	90%
Out-of-Pocket Maximum	Single	$2,300	$6,850
	Family	$4,600	$13,700
U.G. HSA Contribution	Single	$525	N/A
	Family	$1,050	N/A
Preventive Services		100%	100%
Primary Office Visit		100% after Ded	$30 copay
Specialist	Premium Provider	100% after Ded	$30
	Non-Premium Provider		$60
Pharmacy (mail order 2.5 times retail copay)		$10/40/80 after Ded	$10/40/80
Diabetic Supplies & Medications		100% after Ded	100%
ER Services		100% after Ded	$300 copay + Ded + co-insurance
Urgent Care		100% after Ded	$30 copay
Inpatient Hospital		100% after Ded	$400 copay + Ded + co-insurance

UG Employer H.S.A. Pro-rated Contribution

Effective date of health insurance coverage	# Months	HSA Family	HSA Individual
December	1	$125	$63
November	2	$250	$125
October	3	$375	$188
September	4	$500	$250
August	5	$625	$313
July	6	$750	$375
June	7	$875	$438
May	8	$1,000	$500
April	9	$1,125	$563
March	10	$1,250	$625
February	11	$1,375	$688
January	12	$1,500	$750

Please note-the UG employer H.S.A. contribution will be wired to Surency on the first payday AFTER your effective date. It will then take the bank a day or two to post it to your account. This also applied to employee contribution if elected.

Employer Health Savings Account (H.S.A.) Seed Money

Five-year plan (decrease of $150 per year family and $75 per year single)

	1st yr	2nd yr	3rd yr	4th yr	5th yr
Single coverage	$750	$675	$600	$525	$450
Family coverage	$1500	$1350	$1200	$1050	$900

Current employees who elect to enroll on the HDHP during a future Open Enrollment will receive the contribution amount based on the year they enroll onto the HDHP (pro-rated amount if the change is after January)

HSA eligibility requirements

- No coverage by another, non-high deductible health plan, such as a spouse's plan
- Not enrolled in Medicare (this includes any parts of Medicare A, B, D etc.)
- Do not receive health benefits under TRICARE
- No Veterans Administration (VA) benefits within the past 3 months
- Not claimed as a dependent on another person's tax return
- No FSA or HRA health care coverage

REMEMBER: Funds withdrawn for **non-qualified expenses** are included in income & **subject to income taxes plus 20% penalty**

20% additional penalty applies **except** when taken after:

You become eligible for Medicare (age 65)

You become disabled or die

2022 Out of Pocket (OOP) Comparison (family coverage)

		Charge	Employee Impact: HDHP / H S A	Employee Impact: Traditional
Preventive Care - 3 Visits	$	300	$ -	$ -
Lab Work	$	800	$ 800	$ 710
3 Doctor Office Visits	$	240	$ 240	$ 90
5 Prescriptions	$	152	$ 152	$ 120
Outpatient Procedure	$	20,000	$ 1,608	$ 2,630
Subtotal	$	21,492	$ 2,800	$ 3,550
Employer Seed Money from H S A Funds			$ 1,050	N/A
Employee Out-of-Pocket (OOP) Cost Before Premium			$ 1,750	3,550
Annual Employee Family Premium (DOES NOT GO TOWARD OOP MAX)				
Traditional Plan Family Premium Ranges from $4,813-$5,110				
HDHP with H S A Family Premium Ranges from $4,244-$4,541				
Total Employee Cost Including Premium			**$5,994-$6,291**	**$8,363-$8,660**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-633-2446.or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$700** Individual / **$1,400** Family Non-Network: **$1,500** Individual / **$4,500** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$6,850** Individual / **$13,700** Family Non-Network: **$6,850** Individual / **$13,700** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-866-633-2446** for a list of network providers.	You pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit, deductible does not apply.	30% coinsurance after deductible	Virtual visits (Telehealth) - $30 copay per visit by a Designated Virtual Network Provider, deductible does not apply. No virtual coverage non-network If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Designated Network: $30 copay per visit, deductible does not apply. Network: $60 copay per visit, deductible does not apply.	30% coinsurance after deductible	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/screening/ Immunization	No Charge	30% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	30% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance after deductible	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: $10 copay, deductible does not apply. Mail-Order: $25 copay, deductible does not apply.	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied.
	Tier 2 – Your Mid-Range Cost Option	Retail: $40 copay, deductible does not apply. Mail-Order: $100 copay deductible does not apply.	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: $80 copay deductible does not apply. Mail-Order: $200 copay, deductible does not apply.	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/service, then 10% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$300 copay per visit, then 10% coinsurance after deductible	$300 copay per visit, then 10% coinsurance after deductible	None
	Emergency medical transportation	10% coinsurance, deductible does not apply.	10% coinsurance, deductible does not apply.	None
	Urgent care	$30 copay per visit,	30% coinsurance after	If you receive services in addition to Urgent care visit,

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		deductible does not apply.	deductible	additional copays, deductibles, or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copay per visit, then deductible and then then 10% coinsurance,	30% coinsurance after deductible	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60 copay per visit, deductible does not apply.	30% coinsurance after deductible	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Inpatient services	$400 copay per admission, then 10% coinsurance, deductible does apply.	30% coinsurance after deductible	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
If you are pregnant	Office visits	No Charge	30% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	10% coinsurance after deductible	30% coinsurance after deductible	
	Childbirth/delivery facility services	$400 copay per visit, then 10% coinsurance, deductible does apply.	30% coinsurance after deductible	Inpatient preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	30% coinsurance after deductible	Limited to 40 visits per calendar year. Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	$30 copay per visit, then 10% coinsurance, deductible does apply.	30% coinsurance after deductible	Limited to 30 visits per therapy, per calendar year. Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount.
	Habilitative services	$30 copay per visit, then 10% coinsurance, deductible does apply.	30% coinsurance after deductible	Services are provided under and limits are combined with Rehabilitation Services above. Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount.
	Skilled nursing care		30% coinsurance after	Limited to 60 days per calendar year (combined with inpatient

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		$400 copay per visit, then 10% coinsurance, deductible does apply.	deductible	rehabilitation). Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	10% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required non-network for DME over $1,000 or no coverage.
	Hospice services	10% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required non-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	$30 copay per visit, deductible does not apply.	30% coinsurance after deductible	None
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Children's glasses
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine foot care – Except as covered for Diabetes
- Weight loss programs (except for Real Appeal)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic (Manipulative care) – 30 visits per calendar year
- Hearing aids
- Infertility treatment
- Routine eye care (adult)

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$700
Specialist copay	$30
Hospital (facility) copay	$400
Other coinsurance	10%

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,360**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$700
Specialist copay	$30
Hospital (facility) copay	$400
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$700
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,030**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$700
Specialist copay	$30
Hospital (facility) copay	$400
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$500
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,270**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-314-0335.or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$1,400** Individual / **$2,800** Family Non-Network: **$3,300** Individual / **$6,600** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$2,300** Individual / **$4,600** Family Non-Network: **$4,300** Individual / **$8,600** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myuhc.com or call **1-866-314-0335** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance after deductible	30% coinsurance after deductible	Virtual visits (Telehealth) - 0% coinsurance by a Designated Virtual Network Provider. No virtual coverage non-network
	Specialist visit	0% coinsurance after deductible	30% coinsurance after deductible	None
	Preventive care/screening/ Immunization	No Charge	30% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	30% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	30% coinsurance after deductible	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 – Your Lowest Cost Option	Retail: $10 copay after ded. Mail-Order: $25 copay after ded.	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to any applicable copay and/or coinsurance may be applied. Prescription drug costs are subject to the annual deductible.
	Tier 2 – Your Mid-Range Cost Option	Retail: $40 copay after ded. Mail-Order: $100 copay after ded.	Not Covered	
	Tier 3 – Your Mid-Range Cost Option	Retail: $80 copay after ded. Mail-Order: $200 copay after ded.	Not Covered	
	Tier 4 – Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	0% coinsurance after deductible	30% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible	*0% coinsurance after deductible	*Network deductible applies
	Emergency medical transportation	0% coinsurance after deductible	*0% coinsurance after deductible	*Network deductible applies
	Urgent care	0% coinsurance after deductible	30% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Physician/surgeon fees	0% coinsurance after deductible	30% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required non-network for certain services or benefit reduces to 50% of allowed amount.
	Inpatient services	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
If you are pregnant	Office visits	No Charge	30% coinsurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance after deductible	30% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	30% coinsurance after deductible	Inpatient preauthorization applies non-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount.
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	30% coinsurance after deductible	Limited to 40 visits per calendar year. Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Rehabilitation services	0% coinsurance after deductible	30% coinsurance after deductible	Limited to 30 visits per therapy, per calendar year. Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount.
	Habilitative services	0% coinsurance after deductible	30% coinsurance after deductible	Services are provided under and limits are combined with Rehabilitation Services above.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				Preauthorization required non-network for certain services or benefit reduces to 50% of allowed amount.
	Skilled nursing care	0% coinsurance after deductible	30% coinsurance after deductible	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Preauthorization is required non-network or benefit reduces to 50% of allowed amount.
	Durable medical equipment	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required non-network for DME over $1,000 or no coverage.
	Hospice services	0% coinsurance after deductible	30% coinsurance after deductible	Preauthorization is required non-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount.
If your child needs dental or eye care	Children's eye exam	0% coinsurance after deductible	Not Covered	No coverage non-network.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's Dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Children's glasses
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when travelling outside - the U.S.
- Private duty nursing
- Routine foot care – Except as covered for Diabetes
- Weight loss programs (except for Real Appeal)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic (Manipulative care) – 30 visits per calendar year	• Hearing aids • Infertility treatment	• Routine eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. Contact dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-314-0335.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-314-0335.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-314-0335.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-314-0335.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,400
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,400
Copayments (Prescription Drugs)	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,490**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,400
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,400
Copayments (Prescription Drugs)	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,430**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,400
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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 dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

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

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

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

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

DELTA DENTAL

Summary of Dental Plan Benefits

UNIFIED GOVERNMENT OF WYANDOTTE

Group #90102

Effective for January 1, 2022

Maximum Benefit(s) Per Person:

The Maximum Benefit for all Covered Services for each Enrollee in any one Contract Year is: One Thousand Five Hundred Dollars ($1,500.00).

The Maximum Benefit for Orthodontic Services for each Enrollee is: One Thousand Five Hundred Dollars ($1,500.00) during such person's lifetime. Payment for the Orthodontic Services shall not be included in determining the Maximum Benefit for each Contract Year.

Deductible Limitations:

No benefits hereunder are subject to any Deductible amount.

Eligible Children Ages:

Children are eligible to age twenty-six (26).

Benefit % Paid			
Delta Dental PPO	Premier / Non-Participating		
DIAGNOSTIC & PREVENTIVE (Not Subject to Deductible)			
100%	100%	**Diagnostic:**	Includes the following procedures necessary to evaluate existing dental conditions and the dental care required: • Oral evaluations – two (2) times per Contract Year. • Bitewing x-rays – bitewings two (2) times per Contract Year for dependents under age eighteen (18) and once (1) each twelve (12) months for adults age eighteen (18) and over. • Full mouth or panoramic x-rays – once each five (5) years.
100%	100%	**Preventive:**	Provides for the following: • Prophylaxis (Cleanings) – two (2) times per Contract Year. • Topical Fluoride – two (2) times per Contract Year for dependent children under age nineteen (19). • Space Maintainers – for dependent children under age fourteen (14) and only for premature loss of primary molars. • Sealants – once (1) per tooth per lifetime for dependent children under age sixteen (16) when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.
BASIC (Not Subject to Deductible)			
100%	75%	**Ancillary:**	Provides for one (1) emergency examination per Plan year by the Dentist for the relief of pain.
100%	75%	**Oral Surgery:**	Provides for simple extractions.
80%	50%	**Oral Surgery:**	Provides for other oral surgery including pre and post-operative care.
100%	75%	**Regular Restorative:**	Provides amalgam (silver) restorations; composite (white) resin restorations on all teeth; and stainless steel crowns for dependents under age twelve (12).
100%	50%	**Endodontics:**	Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once (1) in any twenty-four (24) month period, per tooth.
80%	80%	**Periodontics:**	a. Includes procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings.
80%	80%		b. Surgical periodontal procedures.
MAJOR (Not Subject to Deductible)			
50%	50%	**Special Restorative:**	When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
50%	50%	**Prosthodontics:**	a. Includes bridges, partial and complete dentures.
50%	50%		b. Repairs and adjustments of bridges and dentures.
ORTHODONTICS (Not Subject to Deductible)			
50%	50%	**Orthodontics:**	Includes orthodontic appliances and treatment, interceptive and corrective, for adults, spouses and eligible dependent children under age twenty-six (26).

This is a summary of benefits only and does not bind Delta Dental of Kansas to any coverage. Subscribers are encouraged to familiarize themselves with the details of their individual plan benefits. Subscribers are responsible for any required copayments, deductibles, or fees for services not covered by their plan at the time services are performed. Please refer to the Description of Dental Care Coverage ("Benefits Booklet") for complete coverage information, including but not limited to any applicable exclusions and limitations. Coverage as described in the employer group's dental benefits contract with Delta Dental of Kansas is binding on all parties and supersedes all other written or oral communications.

Welcome to Delta Dental of Kansas

With Delta Dental of Kansas you receive the expertise of the largest, most experienced dental benefits carrier in the nation, paired with our unparalleled customer service. With your employer, we have designed a dental benefit plan to help protect you and your family's oral health. Regular, preventive dental care is fundamental to making your smile last, and a healthy mouth contributes to your overall wellbeing.

CHOOSING A DENTIST

You are free to go to any dentist of your choice, but there may be a difference in the amount you pay if the dentist is not a Delta Dental in-network dentist. It is to your advantage to choose a **Delta Dental PPO™** or **Delta Dental Premier®** network dentist. Nearly 4 out of 5 dentists nationwide participate with Delta Dental, so chances are excellent your dentist is already in-network. You can search for an in-network dentist at **DeltaDentalKS.com**, on the Delta Dental mobile app or by contacting our customer service team at 800.234.3375.

MANAGING MY BENEFITS

At **DeltaDentalKS.com**, you can log in to your member account to:

- Print your member ID card
- Review your eligibility and benefit information
- See how your claims paid
- Estimate your out-of-pocket costs*
- Sign-up to receive your Explanation of Benefits (EOBs) electronically
- Access member-only discounts
- And more!

Through Delta Dental's mobile app, you can:

- Use your mobile ID card
- Find a dentist
- Estimate your out-of-pocket costs*
- Review your coverage and claims
- Take an oral health risk assessment
- Use the toothbrush timer
- And more!

The Dental Care Cost Estimator provides an estimate and does not guarantee the exact fees for dental procedures, what your dental benefits plan will cover or your out-of-pocket costs. Estimates should not be construed as financial or medical advice. For more detailed information on your actual dental care costs, please consult your dentist and call Delta Dental of Kansas at 800-234-3375.

Unified Government of Wyandotte County/Kansas City - KS

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

Take a sneak peek before enrolling

- You're on the **Insight** Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1-866-804-0982
- For LASIK providers, call 1-877-5LASER6

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out of Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Copay; $130 allowance, 20% off balance over $130	Up to $91
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $70
Lenticular	$25 Copay	Up to $70
Standard Progressive Lens	$80 Copay	Up to $50
Premium Progressive Lens[Δ]	$110 Copay - $200 Copay	Up to $50
Tier 1	$110 Copay	Up to $50
Tier 2	$120 Copay	Up to $50
Tier 3	$135 Copay	Up to $50
Tier 4	$200 Copay	Up to $50
Lens Options *(paid by the member and added to the base price of the lens)*		
UV Treatment	$15	N/A
Tint (Solid and Gradiant)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - age 19 and over	$40	N/A
Standard Polycarbonate - under age 19	$0	Up to $28
Standard Anti-Reflective Coating	$45	Up to $5
Premium Anti-Reflective Coating[Δ]	$57 - $$85	Up to $5
Tier 1	$57	Up to $5
Tier 2	$68	Up to $5
Tier 3	$85	Up to $5
Photochromic/Transitions	$75	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons and Services	20% off Retail Price	N/A
Contact Lens Fit and Follow-up *(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)*		
Standard Contact Lens Fit & Follow-Up:	$40	N/A
Premium Contact Lens Fit & Follow-Up:	10% off Retail Price	N/A
Contact Lenses *(Contact Lens allowance includes materials only)*		
Conventional	$0 copay, $130 allowance, 15% off balance over $130	Up to $105
Disposable	$0 copay, $130 allowance, plus balance over $130	Up to $105
Medically Necessary	$0 copay, Paid-In-Full	Up to $210
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and low price guarantee on discounted hearing aids	
Frequency		
Examination	Once every 12 months	
Lenses (in lieu of contact lenses)	Once every 12 months	
Contacts (in lieu of lenses)	Once every 12 months	
Frame	Once every 24 months	

QL-0000053330

[Δ] Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of anyWorkers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

Underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Get more and see more with EyeMed

72% AVERAGE SAVINGS

on eye exams and glasses for EyeMed members*

CHOOSE A DOC

EyeMed members choose from the right mix of thousands of providers—independent eye doctors, your favorite retail stores and everything in between. Find your ideal fit at eyemed.com or the EyeMed Members App.

CREATE AN ACCOUNT

Get special offers with an account on eyemed.com. Enter your email, choose a password and sign up for emailed savings. Log in 24/7 to view your benefit details or health and wellness information.

MOBILIZE YOUR BENEFITS

The EyeMed Members App makes your benefits easy to understand—and even easier to use. Find an eye doctor near you, schedule an appointment and manage your vision benefits.

Learn more about enrolling in EyeMed vision benefits at **enroll.eyemed.com** and see more of the good stuff

*Based on a sample transaction on the Insight network with a covered exam and eyewear benefits

EyeMed | INDEPENDENT PROVIDER NETWORK + LensCrafters | Pearle Vision | Target Optical | Sears Optical | JCPenney optical

PDF-1609-M-557

Human Resources
Unified Government of Wyandotte County/Kansas City, Kansas
J. Renee Ramirez, Director
701 North Seventh Street, Ste. 646
Kansas City, Kansas 66101
(913) 573-5660 • FAX (913) 573-5006

Insurance Provider Contacts-2022

MEDICAL - United Healthcare Choice Plus Customer Service-POS plan (866)633-2446 www.myuhc.com Group #701653 **United Healthcare Choice Plus H.S.A** Customer Service-Health Savings Acct. (866)314-0335	**UG Road to Wellness Employee Health Center** **www.UGRoadToWellness.com** **(913) 573-WELL or (913) 573-9355** **Road to Wellness Pharmacy** **(913)573-5290** **Cerner-Road to Wellness Program** Bridgette Dawson, Health Navigator (816)201-7000 Support@PrimaryHealthNetwork.com
Employee Assistance Program (EAP) - New Directions (800) 624-5544 or www.ndbh.com/wyandotte/ Company code: Wyandotte **Available 24 hours every day** **CONFIDENTIAL** **A FREE benefit for you and your family. Services to help you reduce stress, adjust to a life change, improve relationships, lead others, care for loved ones, navigate the legal system, balance finances and live healthier.**	**DEFERRED COMPENSATION - ICMA-RC** **Denise Crawford, Retirement Plans Specialist,** 1-888-883-8650 work #, 1-202-553-6578 mobile # or DCrawford@icmarc.org email Web Site: www.icmarc.org Client Services 1(800)669-7400
DENTAL - Delta Dental of Kansas Customer Service Group #90102 (800)234-3375 www.deltadentalks.com	**FSA & HSA - Surency** Flexible Spending Accounts (FSA) AND Health Savings Account (HSA) Customer Service (866)818-8805 www.surency.com
VISION - EyeMed Vision Care, LLC (866)800-5457 Group # 1018539 www.eyemed.com	**Bonnie Bloesser** **Benefits Administrator** **Human Resources Department-Unified Government** Direct line: (913)573-5663 Secure fax: (913)573-5686 Email: bbloesser@wycokck.org
RETIREMENT SYSTEM - KPERS and KP & F **Kansas Public Employees Retirement System** Web Site: www.kpers.org InfoLine: (888)275-5737 Fax: (785)296-6638 E-mail: kpers@kpers.org	REMINDER: If you would like to make changes to your insurance during the middle of the year (add baby, spouse etc.) you have a 31 day window from the date of the event to submit the enrollment form(s) and proof of the event -if you miss the 31 day window you'll have to wait until the next Open Enrollment to make the change-with the exception of a divorce, which is a mandatory change.

Human Resources
Unified Government of Wyandotte County/Kansas City, Kansas
Renee Ramirez, Director
701 North Seventh Street, Ste. 646
Kansas City, Kansas 66101
(913) 573-5660 • FAX (913) 573-5006

Employee Benefits

Change in Dependent Coverage

Employees must notify Human Resources (by submitting completed enrollment forms) within **31 days** if you have any of the following changes to your insurance:

1. Marriage or divorce (ex-spouses are not eligible for our group insurance)
2. Birth of a child
3. Custody change
4. Adoption or placement for Adoption
5. Termination or part-time status of employment by your spouse
6. Your dependent changes full-time student status, graduates, or reaches the maximum age limit

If Human Resources is not notified **in writing** within **31 days**, the employee must wait until the next annual open enrollment period (usually in October) to make the changes that will be effective January 1st of the following year.

These changes may affect one or more of the following:

1. Medical Insurance
2. Dental Insurance
3. Optical Insurance
4. Life Insurance
5. Beneficiary for your life insurance
6. Flexible Spending (Cafeteria) Plan

Signing and submitting enrollment forms within **31 days** makes the changes effective. You are not able to make changes with a phone call.

UNIFIED GOVERNMENT OF
WYANDOTTE COUNTY/KANSAS CITY, KANSAS

Life and Accidental Death & Dismemberment Insurance

SUMMARY OF BENEFITS

This is a summary of your benefits and is not intended to be a detailed description of coverage. The Group Policy contains all the controlling terms and provisions of coverage.

- ***Basic Life Insurance – Provided by The Unified Government***

Coverage Type	*Amount*	*Contribution*	*Eligible*
Basic Life Insurance	$10,000	100% Employer-paid	All full-time and "part-time A" employees
Basic AD&D Insurance	$10,000		

Life Insurance:
- No exclusions or limitations for payment of benefits, no matter what the cause of death.
- Accelerated Death Benefit, up to 75.
- Standard Secure Access interest-bearing checking account for death proceeds
- Portability of coverage. (not applicable to retirees)
- Benefits reduce to 65% at age 70, to 45% at age 75, to 30% at age 80.
- No benefit termination due to age.

AD&D Insurance:
- 24-Hour Coverage
- Seat Belt/Airbag System Benefit up to $10,000.
- Some AD&D Exclusions and Limitations apply.

- ***Dependent Life Insurance – Optional***

Coverage Type	*Amount*	*Contribution*	*Eligible*	*Rate*
Life Insurance: ▪ Spouse ▪ Child	$2,000 $1,000 per child	▪ 100% Employee-paid ▪ Payroll Deducted	All full-time and "part-time A" employees	Flat .48 per month

- If you elect Dependent coverage, you automatically receive the Family Benefits Package (for surviving spouse and children for loss due to accident): includes child care, higher education and career adjustment benefits.
- Continued coverage for disabled child.
- Conversion of coverage.

(continued on back)

- ***Employee Additional Life Insurance – Optional***

Coverage Type	*Amount*	*Contribution*	*Rates*
Employee Additional Life Insurance	▪ Increments of $10,000 ▪ $500,000 max	▪ 100% Employee-paid ▪ Payroll Deducted	➢ Premium rates for Additional Life Insurance coverage for you and your spouse are based on **employee** age as of the preceding January 1: Age — Monthly Rate per Multiples of $10,000 Under 30 $ .60 30 – 39 $ 0.85 40 – 44 $ 1.45 45 – 49 $ 2.65 50 – 54 $ 4.00 55 – 59 $ 6.65 60 – 64 $ 7.30 65 – 69 $12.75 70 – 74 $20.90 75 or over $36.20
▪ If you did not enroll when you were first eligible, medical evidence will be required for all amounts. (please complete a Medical History Statement.)			

- ***Employee Additional AD&D Insurance – Optional***

Coverage Type	*Amount*	*Contribution*	*Rates*
Employee Additional AD&D Insurance	▪ Increments of $10,000 ▪ $500,000 max	▪ 100% Employee-paid ▪ Payroll Deducted	➢ 40¢ (per multiples of $10,000)
▪ If you did not enroll for AD&D when you were first eligible, medical evidence is not required.			
▪ You must have Additional Life Insurance in order to purchase Additional AD&D, and the amount cannot exceed more than your Additional Life coverage.			
▪ Coverage must be purchased in increments of $10,000.			

- ***Spouse Additional Life Insurance – Optional***

Coverage Type	*Amount*	*Contribution*	*Rates*
Spouse Additional Life Insurance	▪ Increments of $10,000 ▪ $250,000 max	▪ 100% Employee-paid ▪ Payroll Deducted	Please refer to rate table in Employee Additional Life section
▪ You must elect Additional Life Insurance for yourself in order to elect Spouse coverage, and Spouse coverage cannot exceed 50% of Employee coverage.			
▪ Medical evidence will be required if you wish to increase your Spouse amount or if you did not enroll for Spouse coverage when you were first eligible. (please complete a Medical History Statement).			

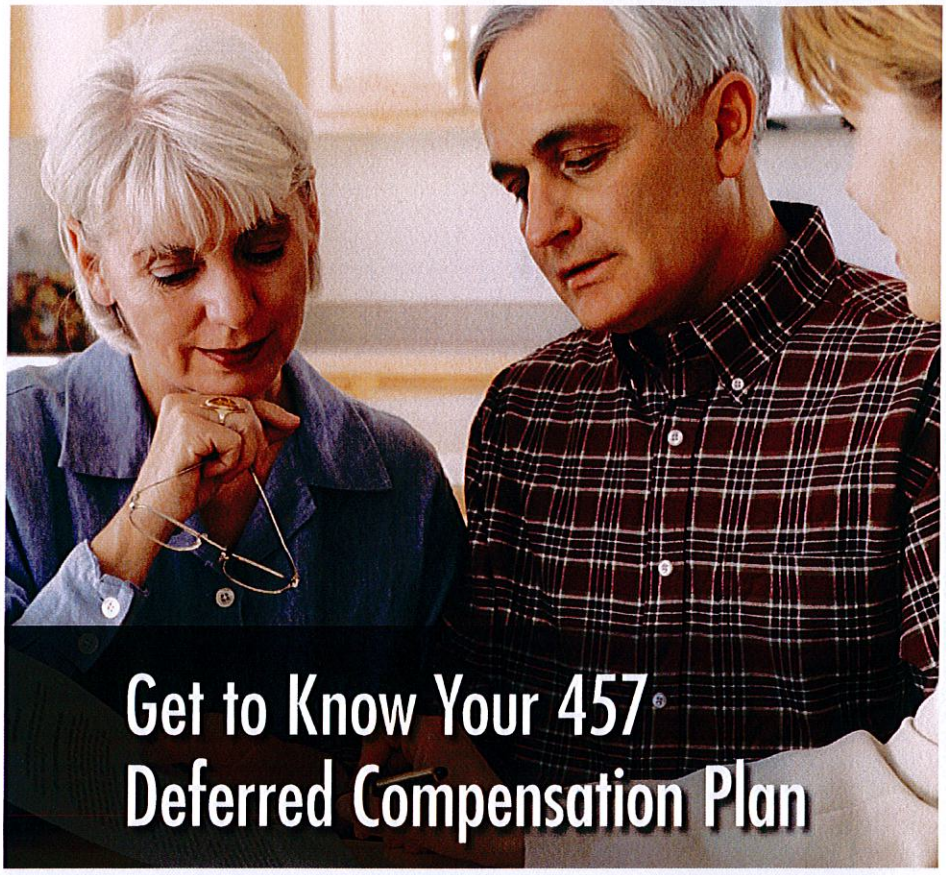
- ***Spouse Additional AD&D Insurance – Optional***

Coverage Type	*Amount*	*Contribution*	*Rates*
Spouse Additional AD&D Insurance	▪ Increments of $10,000 ▪ $250,000 max	▪ 100% Employee-paid ▪ Payroll Deducted	➢ 40¢ (per multiples of $10,000)
▪ You must elect Additional Life Insurance for yourself in order to elect Spouse coverage, and Spouse coverage cannot exceed 50% of Employee coverage.			
▪ Medical evidence is not required if you wish to increase your Spouse amount or if you did not enroll for Spouse AD&D coverage when you were first eligible. Amount of AD&D cannot exceed amount of Additional Life.			
▪ If you are a newly-eligible employee, your Spouse has a Guarantee Issue amount of $20,000. Coverage must be purchased in increments of $10,000.			

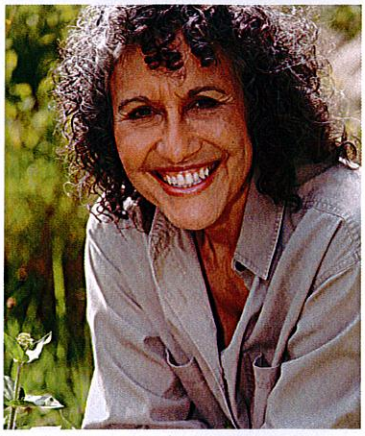
- ***Child Additional Life-only Insurance – Optional***

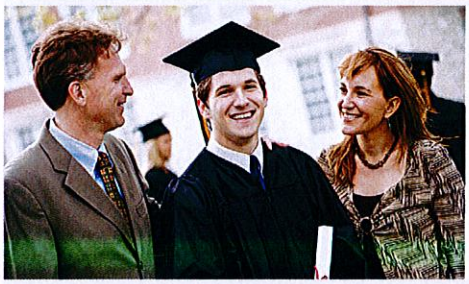
Coverage Type	*Amount*	*Who Pays?*	*Who is Eligible?*
Child Additional Life Insurance	▪ Increments of $2,000 ▪ $10,000 max ▪ Benefit amount is per child	▪ 100% Employee-paid ▪ Payroll Deducted	Employees who have enrolled for Additional Life
▪ You must elect Additional Life Insurance for yourself in order to elect Child coverage, and Child coverage cannot exceed 50% of Employee coverage.			
▪ Medical evidence will be required if you wish to increase your Child amount or if you did not enroll for child coverage when first eligible. (please complete a Medical History Statement for each child).			
▪ If you are a newly-eligible employee, all Child amounts are Guarantee Issue – no medical evidence will be required.			

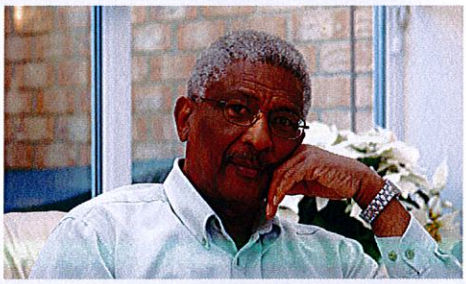
You and your Dependents will receive the same value-added plan features as the Basic Life and AD&D plans.



Get to Know Your 457 Deferred Compensation Plan







ICMA RC

Building Retirement Security

Your **457 DEFERRED COMPENSATION PLAN** is designed to supplement your retirement income. While a pension and/or Social Security will go a long way, they are unlikely to be enough. Saving to your 457 plan can help you maintain your desired standard of living.

A Tax-Advantaged Retirement Plan

A **457 Plan** is a retirement savings plan and investment vehicle with tax advantages.

- Contributions are made to your account during your employment.
- Your account's value is based on those contributions and subsequent investment returns.
- Earnings are not subject to tax until withdrawn.
- You have significant control over:
  - how the money in the account is invested;
  - how funds are withdrawn following your separation from service; and
  - who receives any remaining assets upon your death.

Don't Delay — Start Saving Now. The earlier you start saving, the less pressure you may face later to catch up. And starting early can give you a huge advantage due to compounding, in which your investments produce earnings from previous earnings.

Contributions

Pre-tax contributions you make reduce your taxable income for the year. These contributions and all associated earnings are not subject to tax until you withdraw them, boosting the ability of your account to grow.

You also may be able to make after-tax **Roth contributions.** While they do not reduce your taxable income for the year, future withdrawals may be tax-free. Alternatively, you may contribute to a Roth IRA (www.icmarc.org/ira).

Contribute what you can. For 2013, you can contribute up to $17,500, or $23,000 if age 50 or over. (Participants near to retirement may also be eligible to contribute additional amounts — up to $35,000 total.) But even small savings add up over time. In fact, starting out small and then increasing how much you save by just a little each year may be all you need.

Investment Control

You control all investment decisions, choosing from among the available options. You decide:

- how contributions are invested; and
- how to manage your investments on an ongoing basis.

A wide range of investment options is available to help you build a diversified portfolio. And ICMA-RC can help you make your investment decisions through **Guided Pathways®** (www.icmarc.org/guidedpathways).

Access to Your Money

When you leave your employer, you can withdraw assets, regardless of the reason and your years of service.

Under certain conditions, based on your employer's plan rules, withdrawals may also be allowed while you're still working.

You have the following flexible withdrawal options for vested assets:

- Your entire balance
- Periodic, partial withdrawals as you see fit
- Installment payments of a certain dollar amount and frequency, such as monthly or quarterly; scheduled withdrawals can be changed at any time.
- Lifetime income payments

457 plans are unique. Unlike other retirement accounts, you do not have to qualify for an exception to avoid the 10% IRS penalty tax on withdrawals of your contributions and associated earnings before age 59½. Just remember that your 457 plan is designed to help you meet your retirement goals. Any withdrawals prior to retirement may reduce your future retirement security.

After you reach age 70½ or separate from service, whichever is later, you will be required to withdraw at least a minimum amount from your account each year, per IRS rules.

If plan rules allow, you may also borrow against your vested assets through a loan, subject to IRS rules.

Portability

After leaving your employer, vested assets can also be transferred — or rolled over — to another eligible retirement plan without being taxed.

Survivor Benefits

You designate a beneficiary, or beneficiaries, to receive any remaining assets upon your death. If you don't designate beneficiaries, your estate is the default beneficiary, in which case:

- assets may not be distributed per your wishes;
- assets are subject to probate costs, potential delays, creditor claims; and
- non-spouse heirs may receive fewer tax benefits.

Beneficiaries control investment decisions, receive the most flexible withdrawal options allowed by law, and are not subject to any additional fees.

We Build Retirement Security

Founded in 1972, ICMA-RC is a non-profit independent financial services corporation focused on providing retirement plans and related services for more than a million public sector participant accounts and approximately 9,000 retirement plans. Our mission is to help build retirement security for public employees. We deliver on our mission by focusing on service, quality and value.

For assistance with your 457 plan and your overall retirement goals, contact your ICMA-RC representative.

To manage your account online, log into **Account Access** at www.icmarc.org

You may also obtain general information on our website at: www.icmarc.org/457 or www.icmarc.org/learn

ICMA-RC
Building Retirement Security

ICMA RETIREMENT CORPORATION
777 NORTH CAPITOL STREET, NE | WASHINGTON, DC 20002-4240
800-669-7400
PARA ASISTENCIA EN ESPAÑOL LLAME AL 800-669-8216
WWW.ICMARC.ORG

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Date: 01/01/2020

THE UNIFIED GOVERNMENT OF WYANDOTTE COUNTY KANSAS CITY, KS (#306151) AUTOMATIC ENROLLMENT NOTICE

Investing in a 457 plan is an excellent way to save for your retirement, as your contributions are invested on a tax-deferred basis and are not subject to federal income tax withholding until they are withdrawn from the account. The Unified Government of Wyandotte County Kansas City, KS is committed to helping you build retirement security and is offering an automatic enrollment provision.

Plan Enrollment and Contribution Rate

If you have not already made an election to participate in the Plan, 30 days following the date of this notice in the first pay period of the following month, 2% of your pay will be withheld from each paycheck and contributed to the Plan. You will always be 100 percent vested in your contributions to the plan.

If you choose not to participate in the plan, you must notify ICMA-RC by calling Participant Services at 800-669-7400 within 30 days from receiving this notice to avoid the initiation of automatic contributions. However, prior to or after your contributions have begun, you may elect to increase your contributions above the automatic 2% rate, decrease your contributions below the automatic 2% rate, or stop contributions to the Plan. By taking any of these steps you will no longer be automatically enrolled in the plan. Please see below for more information regarding stopping contributions to the plan.

Investment Options

Your contributions will be automatically invested in the age-appropriate T Rowe Price Retirement Target Date Fund (the "Fund") unless you elect another investment option or options. Once your account is established, you may change how your contributions are invested and, if your plan permits, transfer all or part of your account to another investment option oroptions. Changing your investment options will not be treated as a decision to not be auto-enrolled or as a decision to cease automatic deferrals.

For information about the Fund, please read the T Rowe Price Disclosures Memorandum and the Fund's Fact Sheet carefully for a complete summary of all fees, expenses, investment objectives and strategies, and risks. These materials are available by calling 800-669-7400, or once your account is established, by logging in to Account Access at www.icmarc.org.

If the plan permits and according to your investment lineup, you may change the way your contributions are invested at any time by logging in to Account Access, www.icmarc.org/login, or contacting Investor Services. If you would prefer an investment other than the Fund for your future contributions, no fees or expenses will apply to change your allocation instructions. Investing involves risk, including possible loss of the amount invested. You should carefully consider the information contained in a fund's offering and disclosure documents before investing.

The following chart provides the available Fund your default contribution will be invested in based on the assumption you will retire at age 65*.

If you were born…	Milestone Fund Name
1953 - 1957	T Rowe Price Retirement 2020
1958 - 1962	T Rowe Price Retirement 2025
1963 - 1967	T Rowe Price Retirement 2030
1968 - 1972	T Rowe Price Retirement 2035

1973 - 1977	T Rowe Price Retirement 2040
1978 - 1982	T Rowe Price Retirement 2045
1983 - 1987	T Rowe Price Retirement 2050
1988 - 1992	T Rowe Price Retirement 2055

As an illustration, if you were born in July 1973, your default investment option will be the T Rowe Price Retirement 2040 Fund.
**Calculations that produce a date beyond the currently available T Rowe Price Retirement Funds will default to the T Rowe Price Retirement 2055 Fund.*

Stopping and Receiving a Refund of Contributions

If you wish to stop your participation in the plan, you should call Participant Services at 800-669-7400 or log into your account online.

If you elect to stop your contributions to the plan within 90 days from the date ICMA-RC received your first contribution, you will receive a refund of contributions made through the Automatic Enrollment program plus or minus any associated investment earnings or losses. After the end of the 90-day period, Plan rules limit making withdrawals while you are still employed with The Unified Government of Wyandotte County Kansas City, KS. Since all refunded monies are taxable as normal income, ICMA-RC will provide you with the appropriate tax reporting form.

Other Withdrawals

After you leave employment with The Unified Government of Wyandotte County Kansas City, KS, you will be eligible to make withdrawals from your account, but you are generally not required to begin withdrawals until after you reach age 70½.

While you are still employed with The Unified Government of Wyandotte County Kansas City, KS, you may only take withdrawals for the following circumstances if so elected by your employer:

- After you reach age 70½
- Assets that you rolled-in from another retirement plan
- In certain unforeseeable emergency situations, as defined by the IRS, and permitted by the plan.

You may also be able to make a withdrawal under the following circumstance while still employed:

- Your balance is between $1,000 and $5000 (2020 limit) and no contributions have been made to the plan for at least two years

Withdrawals are generally taxable but, unlike other retirement accounts, the 10% penalty tax generally does not apply to distributions of 457(b) assets prior to age 59½.

Updating Your Account

To change the amount of your contribution or investment selections, update your account information, or learn more about The Unified Government of Wyandotte County Kansas City, KS 457 Deferred Compensation Plan, please utilize ICMA-RC's website at www.icmarc.org or contact ICMA-RC at 800-669-7400.

NEW DIRECTIONS®

EMPLOYEE ASSISTANCE PROGRAM - EAP

When life's a little much,
reach out and get in touch.

Let's be real: life can be tough. When your responsibilities start to feel overwhelming and showing up each day with a smile on your face seems difficult, it's important to reach out for help. You can lean on your free and confidential Employee Assistance Program (EAP) for support.

We've got your back.

A free benefit from your workplace, the EAP can help you or anyone in your household:

- Be more present and productive at work
- Receive support when you don't feel ilke yourself
- Get help with responsibilities that are distracting or stressful
- Grow personal and career skills
- Be a caring, loving friend or family member
- Receive care after a traumatic event or diagnosis
- Make healthy lifestyle choices
- Improve and inspire daily life

We're here for you, always.

Life happens, regardless of the day or time. That's why we make ourselves available 24/7, even on holidays. So whenever you need to reach out, we're here for you.

Support Line
Call anytime
800-624-5544

Mobile app
Search for New Directions EAP

Web
Visit ndbh.com for resources

SERVICES

- ☑ **Counseling**
  - In-person
  - Telephone
  - Text messaging
  - In-the-moment
  - Video
- ☑ **Consultation on**
  - Finances
  - Legal needs
  - Managing employees
  - Life
- ☑ **Crisis support**
- ☑ **Coaching**
- ☑ **Adult and child care resources**
- ☑ **Personal and professional training**
- ☑ **Digital behavioral health tools**

ndbh.com
800-624-5544

Services are free and your employer will not know you reached out.
Flip this sheet over to see some common reasons people use EAP.

Whatever life throws your way, we're here to help.

Stress, relationships, work and money. These are the most common reasons people reach out to the EAP every year. But no matter what issues you're facing, the EAP is the perfect first step for you or your family members to:

Reduce stress
Some stress can be a good thing, but too much can be debilitating and unhealthy. Counseling, assessments, coaching, apps, meditation practices, online tools and more can help you improve areas that need work.

Handle a life curve ball
Divorce, adoption, losing a loved one, career changes and moving can all interrupt one's daily life. Counseling, thousands of online tools, coaching and consultations can help you adjust.

Cope after crisis
Mentally processing and coping after a traumatic event generally takes time and expert care. Counseling, education sheets and communication can help when a crisis occurs.

Support and improve relationships
Raising kids, living with others or improving friendships can take guidance and investment. Counseling, videos, tip sheets and advice make this easier. Referrals to credible daycares, assisted living facilities, dog walkers, physicians, etc. can also help.

Focus at work
We all experience feeling a lack of productivity and engagement at work sometimes. Trainings, advice and custom behavioral strategies can help you become more focused.

Lead others
If you supervise people at work, it's likely you handle difficult things like performance issues, troubled employees, HR law and hard conversations. Dedicated consultants can provide guidance so you can do your job and have less stress.

Navigate the legal system
Handling a landlord, large purchase, estate or even an infraction can be easier with the help of a legal expert and thousands of online templates to put into action.

Reduce debt
Money worries can be minimized with custom action plans developed with a financial expert to save, reduce debt or afford a life desired.

Live a healthy life
Changing behaviors to quit smoking, lose weight, manage a disease or exercise more can be more manageable when broken into baby steps. Coaching, videos, counseling and digital tools can help you start living healthy.

> "The EAP has been beneficial in so many ways I don't know how I would have gotten through without it."

Check out our app.

Search for **New Directions EAP** in your app store.

Available on Google Play

Available on the App Store

Take the first step and call today.

ndbh.com
800-624-5544

UG Road to Wellness
Portal Account Creation

How to Create Your Account:

1. Go to **www.UGRoadtoWellness.com** and click on the blue Primary Health Network Portal Login.

2. Select **"Click here to sign up."**
If you have created an account in the past, you do not need to create a new account.

3. Answer all registration questions. When asked for "Member Number," enter: **UG_9 digit Employee ID**
Enter UG_00000 + four-digit UG ID Number (e.g., UG_000001234).

4. Review and accept Terms of Use and Privacy Policy. Select **"Next."**

Please note: It may take 2-3 weeks for new member information to be entered into the system.

Receive a discount on your visit charge at the UG Employee Health Center by completing your Personal Health Assessment (PHA), available online.

To complete your Personal Health Assessment (PHA) select "Get Started" on your dashboard.

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ROAD TO WELLNESS

Questions?
For questions, contact your Health Navigator, Abby Nowlin, at Support@PrimaryHealthNetwork.com or 816-201-7000.

UG On-Site Clinic Costs

Traditional PPO Plan	Office visit w/PHA	Office visit w/o PHA	Lab work	Preventive
Full time employees	$15	$25	Subject to deductible +10 % co-insur.	$0.00
Part time A employees				
Retirees				
COBRA				
FSB				

Not on insurance	Office visit w/PHA	Office visit w/o PHA	Lab work	Preventive
Opt out waiver employees	$40	$50	Billable charges	$0.00
Part time B employees				

High Deductible Health Plan w/H.S.A.	Office visit w/PHA	Office visit w/o PHA	Lab work	Preventive
Full time employees	$40 or $0.00 if deductible is met	$50 or $0.00 if deductible is met	$0.00 after deductible is met	$0.00
Part time A employees				
COBRA				
FSB				

UNIFIED GOVERNMENT

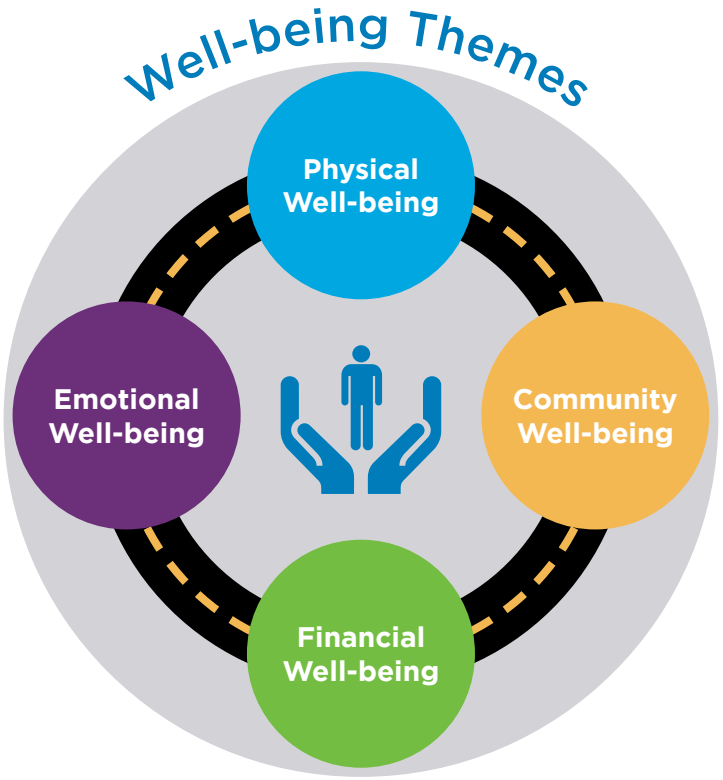
ROAD TO WELLNESS

2022 Incentive Program Guide

Program Start: January 1, 2022
Program End: December 15, 2022

Although the wellness program is voluntary, all eligible employees will be required to complete the Core Requirements in order to be eligible for rewards. Full-time and part-time employees enrolled in the medical plan are eligible. All 2022 rewards will be distributed on your paycheck in January 2023, unless you elected during the 2022 Open Enrollment period to have your reward deposited pre-tax into your HSA.

Log into the wellness portal at UGRoadtoWellness.com to get started!



Step 1

Complete Core Requirements* to earn $75 on your paycheck:

- Personal Health Assessment
- Verified Labs & Biometrics
- Identify a Primary Care Provider (PCP)

** These must be completed to earn any rewards.*

Step 2

Complete 225 points worth of Annual Wellness and Bi-Annual Wellness Activities to earn $225 on your paycheck.

See reverse side for Annual Wellness and Preventive Activity opportunities.

Step 3

Complete 50 points worth of Quarterly Wellness Activities to earn $50 on your paycheck.

See reverse side for Quarterly Wellness Activity opportunities.

Step 4

Earn an additional $100 reward!
If you earn $500 by completing steps 1 - 3 listed above, you will earn an additional $100 on your paycheck at the end of the program year.

Your spouse can earn points toward your Quarterly Wellness Activities!

If your spouse is on the UG medical plan, they can complete the Spouse Wellness Evaluation below. They can contribute up to 25 points per quarter to the employee's quarterly point total for a maximum of 50 points per year.

*For spouse points to assist with the employee's quarterly total, the employee must actively participate in **all 4 quarters** of the incentive program.*

Spouse Wellness Evaluation	
Personal Health Assessment Complete once annually	25
Verified Labs & Biometrics Complete once annually at the Road to Wellness Employee Health Center or with their PCP	25

Retiring this year?

You have until your last day of employment to earn points for rewards. You can still use the Road to Wellness Employee Health Center as a retired employee! For more information, log into your wellness portal at UGRoadtoWellness.com.

Questions? Contact Consumer Support at 800.642.2275 or Support@PrimaryHealthNetwork.com.

2022 Incentive Program

Core Requirements

Step 1: Complete Core Requirements to earn $75 at the end of the program year.

All three steps are required		
Personal Health Assessment	*Complete once annually*	25
Verified Labs & Biometrics	*Complete once annually at your worksite, the Road to Wellness Employee Health Center, or with your PCP*	25
Identify a Primary Care Provider (PCP)	*Identify a PCP in the community or at the Road to Wellness Employee Health Center*	25

Annual & Bi-Annual Wellness Activities

Step 2: Complete 225 points in Wellness Activities to earn $225 at the end of the program year.

Tobacco Free (Only one can be completed, once annually)		Annual Max Points
Tobacco Free Verification	*Complete the form located on your Road to Wellness portal*	25
Complete 12-week Tobacco Cessation	*Commit to quit by enrolling in our Tobacco Cessation program*	75
Wellness and Preventive Activities		**Annual Max Points**
COVID-19 Shot(s)	*Points awarded once manufacturer reccomended dose(s) are complete.*	50 NEW
Annual Flu Shot	*Can only be completed once per year*	50
Dental Exam	*Can be completed twice per year; 25 points/visit*	50
Eye Exam	*Can only be completed once per year*	25
Annual Physical Exam	*Can only be completed once per year*	75
Fill a prescription at the Road to Wellness Pharmacy	*Awarded once if you: fill a new prescription, refill a prescription, or transfer a prescription*	25
Physical Activities (Can be earned daily)		**Annual Max Points**
Cardio Logging	*Log 30 minutes of cardio exercise = 1 point; up to 1 point/day*	55
Strength Logging	*Log your strength exercise = 1 point; up to 1 point/day*	55
Steps Tracking	*1 point earned with every 5,000 steps, maximum of 10,000 steps per day; up to 2 points/day*	55

Quarterly* Wellness Activities

Step 3: Complete 50 points in Quarterly Activities to earn $50 (max $200/yr) at the end of the program year.

Health Management (Can be earned quarterly)		Quarterly Max Points
Health Coaching	*In-person or telephonic, 25 points/visit*	25
Well-being Education		**Quarterly Max Points**
Online Workshops	*Varying points/workshops*	30
Online Wellness Classes	*10 points/class*	30
Quarterly Theme Activities		**Quarterly Max Points**
Well-being Classes	*25 points/class (in-person)*	50
Well-being Event Participation	*Q1 Challenge, Q2 Challenge, Q3 Challenge, and Q4 Challenge*	25
Spouse Wellness Evaluation		**Quarterly Max Points**
Personal Health Assessment	*Complete once annually*	25
Verified Labs & Biometrics	*Complete once annually at the Road to Wellness Employee Health Center or with their PCP*	25

*Quarter 1: Jan - Mar 2022 | Quarter 2: Apr - Jun 2022 | Quarter 3: Jul - Sep 2022 | Quarter 4: Oct - Dec 2022

Step 4: Earn an additional $100 reward for staying engaged all year!

If you earn $500 by completing steps 1 - 3 listed above, you will earn an additional $100 at the end of the program year.