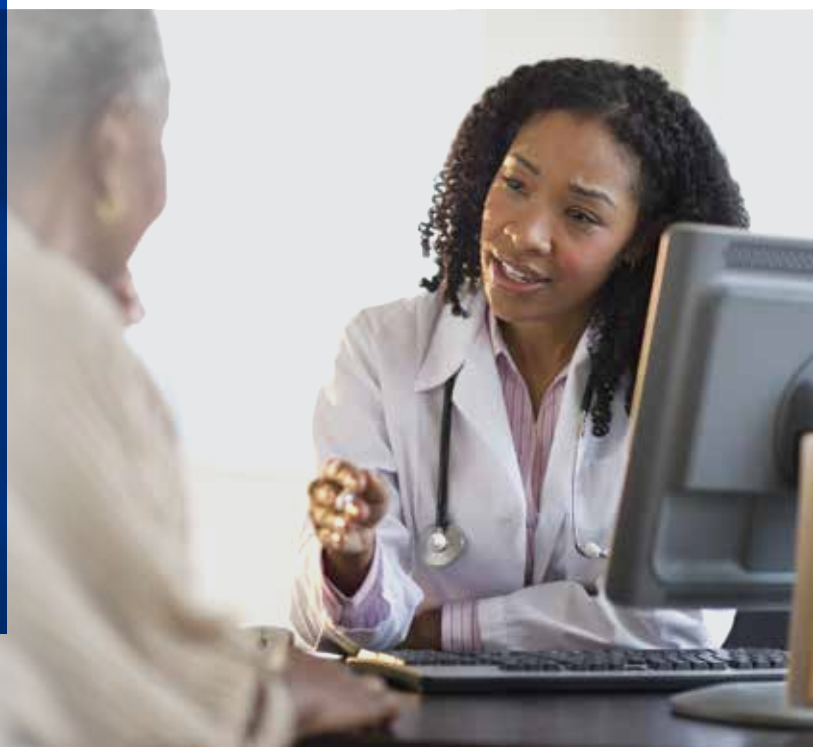
NON-MEDICARE ELIGIBLE

Choosing the non-Medicare medical plan that's right for you



Understanding how much you can expect to pay

Your out-of-pocket costs and your deductible – the amount you must pay each year before the plan begins to pay – will be different, depending on the plan you choose.

PPO

With this plan, you pay a fixed copay for many services, which count toward your out-of-pocket costs. **Copays do not count toward the deductible.**

Network deductibles	Out-of-network deductibles
For 2022, your deductible for services in the network is:	The individual out-of-network deductible applies to each enrolled family member and does not have a family deductible limit:
$500 for individual (single) coverage	**$1,000 for each individual (single)**
$1,000 for family coverage*	**Unlimited for family coverage**

*If you cover family members, **the network family deductible is met when the combined eligible network expenses for you and/or your covered family members reach $1,000.** If one family member reaches $500 but the combined family deductible of $1,000 has not been met, the member who met the $500 deductible can move to coinsurance until one more family member reaches the deductible. If no family member reaches the $500 deductible but the combined family deductible is met, all family members move to coinsurance.

Need more details?
Visit **pebcinfo.com**.

HDP

The HDP does not use copays. You pay 100% of the allowable cost for network services – including office visits, urgent care, prescription drugs, emergency room visits and other covered expenses – until your deductible is met. Once the deductible is met, you pay a portion of the costs as coinsurance.

The deductibles are another big difference between this plan and the PPO plan:

- **$1,500 individual (single) deductible**
- **$3,000 family deductible***

*If you cover any family member, **the entire network family deductible must be met before any family member can move to coinsurance**. The HDP network family deductible is met when the combined eligible expenses for you and/or any covered family members reach $3,000. Even if one family member reaches the $1,500 deductible, that member cannot move to coinsurance until the full $3,000 family deductible is met.

Pre-certification

If care is provided by a network doctor, hospital or other health care provider, you do not need pre-certification for services. If you receive care from an out-of-network provider, your care must be pre-certified or you may incur higher costs. It is your responsibility to make sure your out-of-network care is pre-certified.

Network

To locate a doctor, hospital or other provider in UnitedHealthcare's Choice Plus network, visit **myuhc.com**. While each plan includes out-of-network benefits, you will often pay more for care received from an out-of-network provider.

Transition benefits

Are you new to the HDP or PPO plan? Transition of Care is a service that enables new enrollees to receive time-limited care for specific medical conditions from an out-of-network doctor but at the network benefit level. Complete Sections 1 and 2 of the Application for Transition of Care form (available at **pebcinfo.com** or from your Human Resources department). Ask your doctor to complete Section 3 and forward to UnitedHealthcare no later than 30 days after your benefits become effective. Transition benefits may apply if you are in your second or third trimester of pregnancy, a high-risk pregnancy, in nonsurgical treatment (radiation, chemotherapy) for cancer, treatment for symptomatic AIDS, treatment for severe or end-stage kidney disease, or if you are on the waiting list for or recently underwent a bone marrow or organ transplant.

Questions?
Talk to your Human Resources representative.