

Teammate Benefits Plans

IN-NETWORK MEDICAL BENEFITS	BLUE PLAN	BRONZE PLAN		
Network	UnitedHealthcare Options PPO	UnitedHealthcare Choice Plus		
Calendar Year Deductible (Individual / Family)	\$0/\$0	\$3,000 / \$6,000		
Maximum Calendar Year Out of Pocket (Individual / Family)	N / A	\$6,000 / \$12,000		
PROFESSIONAL SERVICES	Your responsibility is:	Your responsibility is:		
Primary Care Visits	\$5 Copay, first 2 visits, \$25 Copay, visits 3 to 6	\$5 Copay, first 2 visits, \$25 Copay, visits 3+		
Specialist Visits	\$50 Copay, up to 4 visits per year	\$50 Copay		
Urgent Care (For non-emergency medical issues, consider using the RelyMD service)	\$10 Copay, up to 6 visits per year	\$50 Copay		
Preventative Services	Covered 100%	Covered 100%		
Teledoctor	\$0 Copay	\$0 Copay		
	FIXED DOLLAR REIMBURSEMENT	DEDUCTIBLE AMOUNT		
X-RAY / LAB	Plan Will Cover Up To:	Your Responsibility Is:		
X-ray Services	\$1,000 up to 5 per year	Deductible then 20%		
Laboratory Services	\$500 up to 12 per year	Deductible then 20%		
Magnetic Resonance Imaging (MRI)	\$1,600 up to 1 per year	Deductible then 20%		
Computerized Tomography (CT) Scan	\$1,500 up to 1 per year	Deductible then 20%		
EMERGENCY ROOM VISIT	Plan Will Cover Up to:	Plan Will Cover Up to:		
Emergency Room Visits	N/A	\$500 Copay, then Deductible + 20%		
INPATIENT/OUTPATIENT BENEFITS	Plan Will Cover Up to:	Your responsibility is:		
Inpatient Surgery	N / A	Deductible then 20%		
Inpatient Mental Health Benefit	N / A	Deductible then 20%		
Inpatient Alcohol & Substance Abuse Benefit	N / A	Deductible then 20%		
Inpatient Doctor Benefit	N / A	Deductible then 20%		
Outpatient Surgery	\$2,000 up to 1 per year	Deductible then 20%		
Anesthesia Services	\$2,000 up to 1 per year	Deductible then 20%		
Outpatient Mental Health Benefit	\$500 up to 24 per year	Deductible then 20%		
Outpatient Alcohol & Substance Abuse Benefit	\$500 up to 24 per year	Deductible then 20%		
Outpatient Doctor Benefit	\$125 up to 10 per year	Deductible then 20%		
PRESCRIPTION DRUGS	Your responsibility is:	Retail (30 days)	Mail Order (90 days)	
Generic	\$5 Copay	\$15 Copay	\$30 Copay	
Preferred Brand	N / A	30%, minimum \$35	30%, minimum \$70	
Non-Preferred Brand	N / A	40%, minimum \$70	40%, minimum \$150	
PLAN RATES	Teammate Weekly Cost	Payrate: \$10 - \$14.99	Payrate: \$15 - \$16.99	Payrate: \$17+
Teammate Only	\$19.82	\$27.79	\$41.70	\$47.25
Teammate & Spouse	\$48.38	\$154.60	\$169.71	\$175.75
Teammate & Children	\$58.46	\$124.53	\$139.64	\$145.68
Family	\$82.69	\$285.91	\$301.01	\$307.05

IMPORTANT: The benefits described here apply only to IN-NETWORK providers. Out-of-network providers may charge you the difference between what your plan pays and the full cost of the service. You MUST confirm that the provider or facility you choose is in-network before your visit. The MEC plan does not cover out-of-network providers or facilities. If you use an out-of-network provider, you will be responsible for the full cost of the service or visit.

Finding a Provider

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

Updated 10/17/2025

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