GAUMC
General Agencies of The United Methodist Church

2023

GAUMC

Employee Benefits Enrollment Guide

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WELCOME

to the Benefits Information Guide for the GAUMC Employee Benefits Program!

Elections you make during open enrollment will become effective January 1, 2023.

GAUMC offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

ELIGIBILITY

WHO IS ELIGIBLE

FULL-TIME EMPLOYEE BENEFITS

(30+ HOURS PER WEEK*)

MEDICAL INSURANCE

PRESCRIPTION DRUG INSURANCE

SPENDING ACCOUNTS

DENTAL INSURANCE

VISION INSURANCE

COMPANY-PAID TERM LIFE INSURANCE

COMPANY-PAID SHORT-TERM DISABILITY PAY

COMPANY-PAID LONG-TERM DISABILITY INSURANCE

SUPPLEMENTAL AND DEPENDENT LIFE INSURANCE

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

VOLUNTARY BENEFITS

WELLNESS PROGRAMS AND INCENTIVES

EMPLOYEE ASSISTANCE PROGRAM

PART-TIME EMPLOYEE BENEFITS

EMPLOYEE ASSISTANCE PROGRAM

You are eligible for a variety of benefits, including health and welfare programs as listed on the left.

You are eligible for health and welfare benefits on the first day of the month following your hire date. If your hire date is the first day of the month, you are eligible as of your hire date. If you do not enroll within the first 30 days of your hire date, you may only enroll during the next Open Enrollment period or if you experience a qualifying life event.

Example: If you are hired on March 1, you are eligible for benefits coverage to begin on March 1, and you only have until March 31 (30 days after hire date) to enroll in benefits. If you are hired on March 2, you are eligible for benefits coverage to begin on April 1, and you only have until April 1 (30 days after hire date) to enroll in benefits.

Temporary and seasonal employees are not eligible for employee benefits described in this guide.

**As of January 1, 2019, "full-time" is defined as being regularly scheduled to work at least 30 hours per week. All employees of Program Sponsors who were hired prior to January 1, 2019, and who were, and continue to be, regularly scheduled to work at least 20 hours per week, will continue to be Eligible Employees for "full-time" benefits.*

DEPENDENTS

WHO IS A DEPENDENT

Eligible spouse* For purposes of the Program, "spouse" shall include opposite-sex and same-sex spouses (recognized by a state as being legally married to the Eligible Employee or Eligible Former Employee) and civil partners, either through a civil union or a comprehensive domestic partnership (recognized by a state as being the legal partner of the Eligible Employee or Eligible Former Employee). A Surviving Spouse of a Former Employee (Retiree) who was enrolled in benefits prior to the Former Employee's death will remain eligible for benefits until the Surviving Spouse's death or remarriage.

Eligible child* To be eligible under the Program, the child must be your child ("child" includes your natural child, stepchild, foster child, legally adopted child of, or child placed for legal adoption with you, or any child for whom you have legal guardianship) who:

- For the purposes of the medical plan, prescription drug plan, dental plan, vision plan, dependent life insurance plan, and accidental death & dismemberment plan, has not yet attained age 26.
- For purposes of the health care flexible spending account, your dependent must be claimed on your tax return and cannot file their own return.
- For purposes of the dependent care flexible spending account, meets the definition of "dependent" in the flexible spending account section of this Benefit Guide; and
- For purposes of the employee assistance program, and any other insurance plan not listed above, meets the definition of "dependent" in the benefits booklets for each such insured plan.

Coverage may also be available under certain benefit program(s) beyond the maximum ages described above for an unmarried disabled dependent child. You may be required to submit proof of the child's disability for coverage to continue and to submit annual verification of the child's disabled status. Refer to the applicable benefit program booklet(s) for information.

** Upon initial enrollment and at any time thereafter, the Program Sponsors and the Program Administrator (and its delegate) reserve the right to request and require proof of dependent status.*

Choose your plan selections carefully!

The open enrollment period begins
October 24, 2022 and ends November 9, 2022.

ENROLLMENT

EVERYONE MUST finalize and SIGN AND SUBMIT an Open Enrollment session in **Paycom** to continue coverage in 2023. NO benefits will roll over unless you complete your Open Enrollment session in **Paycom**. An Instruction and Troubleshooting guide will be available for your use on the welcome screen in the Benefits Enrollment session. If you have any questions, please contact your Human Resources department.

The open enrollment period begins **October 24, 2022 and ends November 9, 2022.** The benefits you elect during open enrollment will be effective from January 1, 2023 through December 31, 2023.

If you're enrolling as a new employee, you become eligible for benefits the first of the month following your hire date and must enroll within 30 days of your hire date to have coverage for the rest of the plan year. If you are a new employee starting after Open Enrollment closes and before January 1 of the next year, please talk to your Human Resources department to enroll in the next year's benefits.

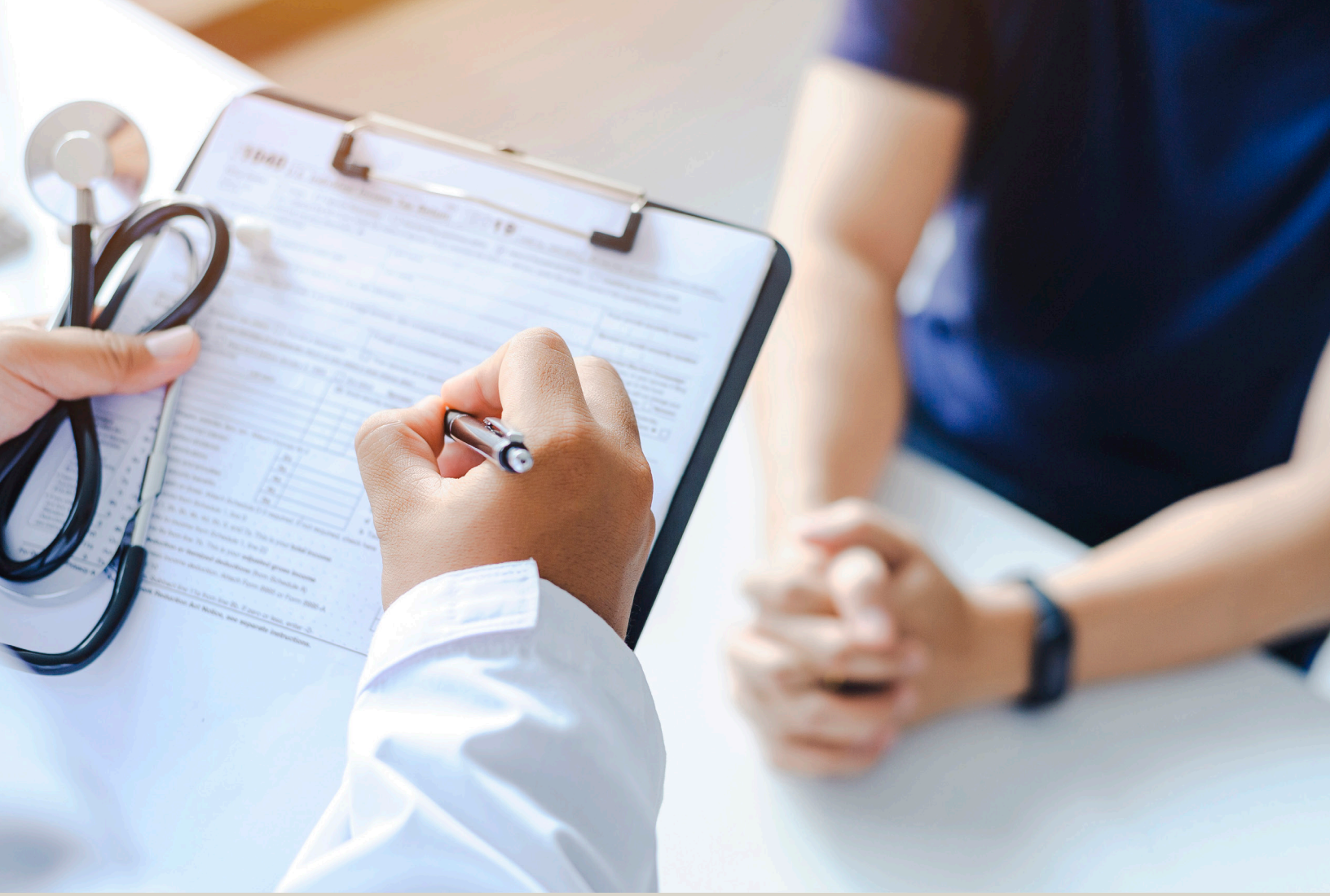
MAKING CHANGES

You cannot make changes to your benefit plans through the plan year unless you have a qualifying life event (change in status). Qualified changes in status include marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, commencement or termination of adoption proceedings, or change in spouse's benefits. Changes due to qualifying life events MUST be made within 30 days of the date of the event. Late enrollments cannot be accepted due to IRS regulations of Section 125 plans.

TERMINATION

Your medical, dental, vision, spending account, employee assistance program, and voluntary benefits coverage ends on the last day of the month in which you separate employment or become ineligible. All other plans, programs, and coverages end at midnight on the day you separate your employment or become ineligible.

You can continue your medical, dental, vision and/or spending accounts (plus a 2% admin fee for spending account processing) through continuing coverage for up to 18 months, or through the plan year only for spending accounts. Please contact your Human Resources department for details.



MEDICAL AND PRESCRIPTION DRUGS

Each person's health care needs are different. That's why our medical plan offers multiple options so you can choose the coverage level best-suited to your personal situation. You pick the one plan that fits your medical and prescription drug needs. You will receive a medical card from United Healthcare and a prescription drug card from Express Scripts.

PPO $500 / $1,000

This PPO plan gives you the freedom to see any physician or other health care professional from the network, including specialists, without a referral. You may also choose to seek care outside the network, subject to higher deductibles, co-payments, and co-insurance. Please note that your medical plans are more cost effective if you seek providers that are in network.

SERVICES	IN NETWORK	OUT OF NETWORK
Annual Deductible - Individual - Family	 $500 per covered person $1,000 for all covered persons	 $1,200 per covered person $2,400 for all covered persons
Out of Pocket Maximum* - Individual - Family	 $4,000 per covered person $8,000 for all covered persons	 $8,000 per covered person $16,000 for all covered persons
Preventive Care	Plan pays 100%, no co-pay	**NOT COVERED**
Physician/Specialist Office Visit	$20 Primary/$40 Specialist	50% of eligible expenses AFTER deductible
Hospitalization Outpatient Surgery Diagnostic Services Urgent Care	 20% of eligible expenses AFTER deductible	 50% of eligible expenses AFTER deductible
Emergency Room	20% of eligible expenses AFTER deductible	20% of eligible expenses AFTER deductible
Prescription Drugs through Express Scripts Retail/Mail Order - Generic - Preferred - Non-Preferred	 $10/$20 $30/$60 $50/$100	Mail order only available in-network $10 $30 $50

*The out of pocket maximum includes your deductible, coinsurance, and medical and prescription copayments. After reaching your deductible, you continue to pay copayments and coinsurance until you reach the out of pocket maximum.

Prior notification is required before you receive certain covered health services. In general, network providers are responsible for notifying the claims administrator before they provide these services to you. There are some network benefits, however, for which you are responsible for notifying the claims administrator. When you choose to receive certain covered health services from non-network providers, you are responsible for notifying the claims administrator before you receive these covered health services. Please refer to your summary plan description for detailed schedule of benefits.

PPO $2,000 / $4,000

This PPO plan gives you the freedom to see any physician or other health care professional from the network, including specialists, without a referral. You may also choose to seek care outside the network, subject to higher deductibles and co-insurance. Please note that your medical plans are more cost effective if you seek providers that are in network.

SERVICES	IN NETWORK	OUT OF NETWORK
Annual Deductible - Individual - Family	 $2,000 per covered person $4,000 for all covered persons	 $4,000 per covered person $8,000 for all covered persons
Out of Pocket Maximum* - Individual - Family	 $6,000 per covered person $12,000 for all covered persons	 $12,000 per covered person $24,000 for all covered persons
Preventive Care	Plan pays 100%, no co-pay	**NOT COVERED**
Physician/Specialist Office Visit.	$20 Primary/ $40 Specialist	50% of eligible expenses AFTER deductible
Hospitalization, Outpatient Surgery, Diagnostic Services, Urgent Care	20% of eligible expenses AFTER deductible	50% of eligible expenses AFTER deductible
Emergency Room	20% of eligible expenses AFTER deductible	20% of eligible expenses AFTER deductible
Prescription Drugs through Express Scripts Retail/Mail Order - Generic - Preferred - Non-Preferred	 $10/$20 $30/$60 $50/$100	Mail order only available in-network $10 $30 $50

*The out of pocket maximum includes your deductible, coinsurance, and medical and prescription copayments. After reaching your deductible, you continue to pay copayments and coinsurance until you reach the out of pocket maximum.

Prior notification is required before you receive certain covered health services. In general, network providers are responsible for notifying the claims administrator before they provide these services to you. There are some network benefits, however, for which you are responsible for notifying the claims administrator. When you choose to receive certain covered health services from non-network providers, you are responsible for notifying the claims administrator before you receive these covered health services. Please refer to your summary plan description for detailed schedule of benefits.

HDHP $1,500 / $3,000 WITH HEALTH SAVINGS ACCOUNT (HSA) OPTION

The High Deductable Health Plan (HDHP) gives you the freedom to see any physician or other health care professional from the network, including specialists, without a referral. You may also choose to seek care outside the network, subject to higher deductibles and coinsurance. Please note that your medical plans are more cost effective if you seek providers that are in network. **Your employer will contribute $500 to your health savings account in January of the new plan year!** New hires receive a prorated employer contribution. This contribution to your health savings account will assist in your out of pocket costs throughout the year.

SERVICES	IN NETWORK	OUT OF NETWORK
Annual Deductible - Individual - Family*	 $1,500 per covered person **$3,000 for all covered persons***	 $3,000 per covered person $6,000 for all covered persons
Out of Pocket Maximum - Individual - Family	 $5,000 per covered person $10,000 for all covered persons	 $10,000 per covered person $20,000 for all covered persons
Preventive Care	Plan pays 100%	**NOT COVERED**
Physician/Specialist Office Visit, Hospitalization, Outpatient Surgery, Diagnostic Services, Urgent Care	20% of eligible expenses AFTER deductible	50% of eligible expenses AFTER deductible
Emergency Room	20% of eligible expenses AFTER deductible	20% of eligible expenses AFTER deductible
Prescription Drugs Retail/Mail Order - Generic - Preferred - Non-Preferred	 20% of eligible expenses AFTER deductible	Mail order only available in-network 50% of eligible expenses AFTER deductible

*For employees enrolling in Employee + 1 or Employee + Family, the family deductible must be paid by one or more persons before the 20% coinsurance applies to eligible charges.

Prior notification is required before you receive certain covered health services. In general, network providers are responsible for notifying the claims administrator before they provide these services to you. There are some network benefits, however, for which you are responsible for notifying the claims administrator. Please refer to your summary plan description for detailed schedule of benefits.

Carefully review which plan is optimal for you and your covered dependents. Also, remember providers who are currently in network providers may or may not STILL be in network providers in 2023. While most providers DO continue with the network from year to year, always check with your providers at the time of service to verify network participation.

To find a United Healthcare Provider, visit UHC's website at www.myuhc.com or call their customer service hotline listed on the back of your ID card. Myuhc.com offers the resources you need to view your claims, search for in-network providers and facilities, manage care and cost. Only members who are changing plans in 2023 will receive a new UHC ID card. Don't forget to use your Express Scripts ID card for prescription drug purchases.

YOUR 2023 MEDICAL PLAN COSTS

Monthly medical premiums are as shown:

	$500 PPO	$2,000 PPO	$1,500 HDHP
Employee	$197.53	$77.04	$78.02
Employee + 1 Dependent	$494.13	$243.51	$245.57
Family	$641.43	$316.11	$318.76

Before Your Preventive Care Visit

Go to www.uhc.com/health-and-wellness/preventive-care prior to your appointment to get a list of preventive services covered for your gender and age. However, if you have a prior diagnosis, you may be charged for a service that could be considered preventive for someone else.

- Make sure your doctor is in your health plan's network
- Be clear when you schedule a doctor visit. Let them know you're only interested in no-cost preventive services. Discussion about other issues that are not preventive (such as asking about a hurt back), may result in an additional charge for an office visit.
- Don't be afraid to ask questions about costs.
- Make sure your doctor uses a lab that is in your health plan's network.

Controlling Health Care Costs

The rising cost of health insurance is a concern for all of us. Keeping costs to a minimum contributes to lower premiums in future years. Here are tips on how you can help lower the cost of health insurance:

- Use network providers. You will receive a higher level of benefits if you use providers who participate in the network.
- Request generic rather than brand name prescription drugs. Generic medications, while just as effective, are considerably less expensive.
- Use the Find Care & Costs tool on myuhc.com to compare facility pricing before having medical services performed.
- Consider seeing your family physician rather than a specialist. Family physicians can often provide the same level of care for a variety of illnesses and conditions.
- Exercise and maintain a proper diet. The healthier you are, the less vulnerable you are to disease, reducing doctor's visits and prescription medicines.

If we become more aware consumers, we can each do our part to lower the cost of health care!

HEALTH MANAGEMENT & WELLNESS PROGRAM

UNITED HEALTHCARE OFFERS
THE FOLLOWING PROGRAMS
TO ITS MEMBERS

ADVOCATE4ME (UNITED HEALTHCARE)

Advocate4Me is designed to help members successfully navigate the health care system by matching them with expert advocates who guide them when they have questions. Advocates have a wide range of qualifications, from nursing degrees to complex claims resolution. Members can use this resource as their single point of contact, giving them a clear way to get support to make more informed health care choices and get the most out of their benefits.

Whether it's through one-on-one conversations or by using online tools, advocates guide employees and their covered family members when they have questions about their health and health plan. With access to specific member data, advocates are able to find personalized solutions for each member's situation – which helps improve outcomes and lower costs.

Advocate4Me offers members service, support and access that goes above and beyond, helping to improve the health care experience, one person at a time. For more information, contact your UnitedHealthcare representative.

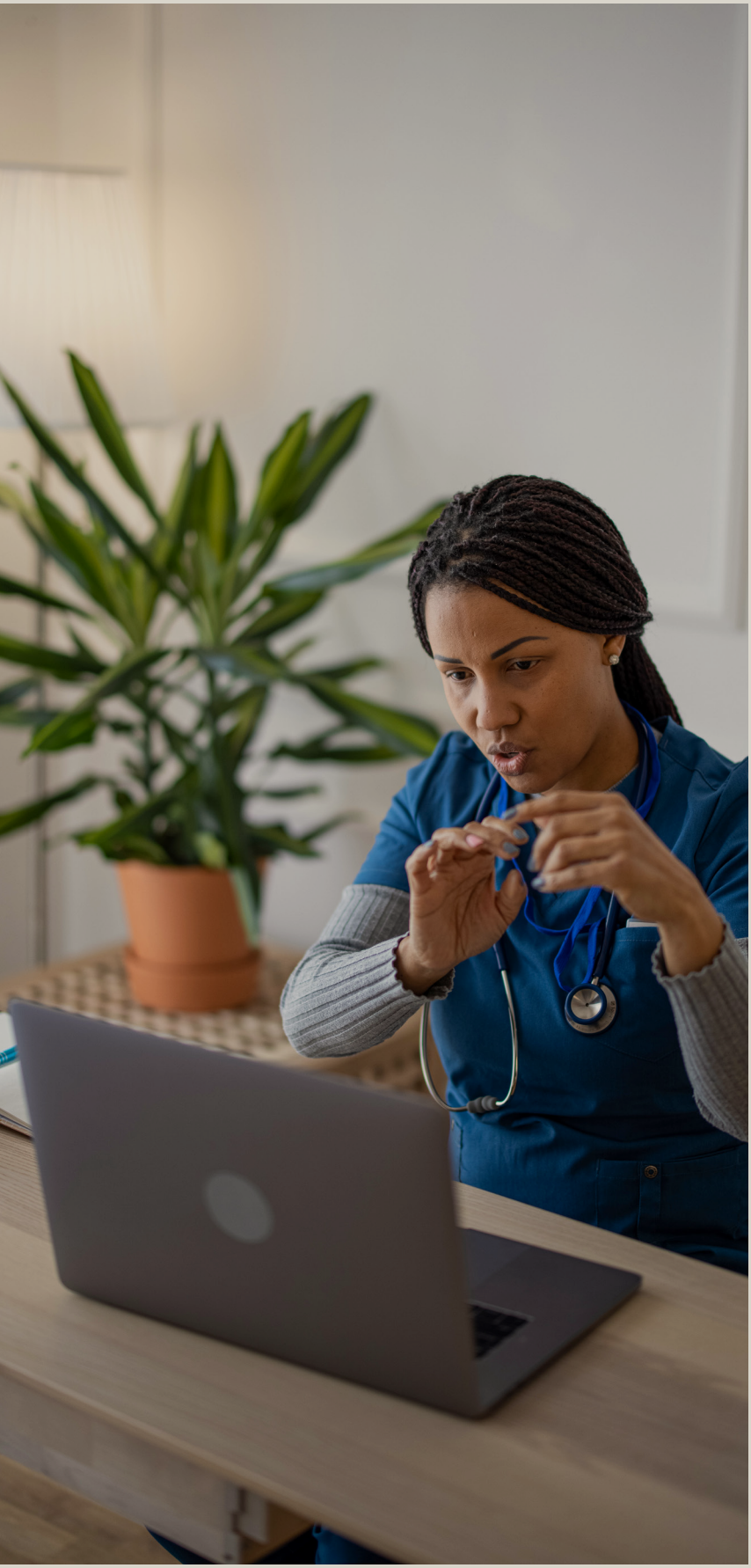
DISEASE MANAGEMENT SUPPORT PROGRAMS (UNITED HEALTHCARE)

When you live with an ongoing health condition, support programs can be a helpful way to get guidance along the way. You can look to support programs to get you in touch with experts who are trained to help you find healthy ways to cope, help you learn to live a rewarding life and overcome challenges you may face.

Learn more about UnitedHealthcare's disease management programs for conditions such as:

- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure
- Coronary Artery Disease
- Asthma

With UnitedHealthcare disease management support, you will never have to walk alone. Sign in to your account or call the number on your member ID card for more information about the Disease Management program.



VIRTUAL VISITS

A virtual visit allows you to see and talk to a doctor from the comfort of your home or office without an appointment. This is a covered service through your health benefits. Appointments can be made by mobile device or computer. Most visits take approximately 10-15 minutes. Doctors can also write a prescription, if needed, that you may pick up at your local pharmacy.

With the $500 deductible and $2,000 deductible plans, the copay for the virtual visit will match the plan copay of $20.

For employees in the $1,500 high deductible plan, the cost of the virtual visit will be about $49; lower than visiting a doctor in their office. If you have not met the deductible, the visit will apply to the deductible. If the deductible has already been met, you will be responsible for the coinsurance.

WHEN SHOULD I USE A VIRTUAL VISIT?

- When your doctor is not available
- When you become ill while traveling
- When you are considering visiting a hospital emergency room for a non-emergency health condition

WHAT CAN I TALK TO THE VIRTUAL VISIT DOCTOR ABOUT? Non-emergency conditions, including:

- Allergies
- Bladder infection
- Bronchitis
- Cough/cold
- Diarrhea
- Fever
- Pink eye
- Rash
- Seasonal flu
- Sinus problems
- Sore throat
- Stomach ache

ACCESS VIRTUAL VISITS

- Login to myuhc.com
- Click on the "Physician & Facilities" tab at the top of the page
- There you will find information where you can:
  - Learn more about virtual visits, and
  - Access direct links to provider sites where you can register and receive care.

DENTAL COVERAGE

Delta Dental will continue to be your provider of dental coverage for 2023. GAUMC employees will be able to choose between two comprehensive dental insurance plans: a Base plan and a Traditional plan. There are no changes to the plan designs in 2023. Always ask your dentist for a Predetermination of Cost of Services before having any dental work done.

Base Plan:

Your dental services are most cost effective when visiting an in network provider. You may seek services through non network providers, but you may be balance billed for your services. Balance billing means the provider may charge you the difference between the cost of the service and the allowed amount that Delta Dental will pay.

The Base plan excludes diagnostic and preventive services from your annual calendar year maximum, allowing the entire annual maximum to apply to basic and major services. The difference between the Base plan and Traditional plan is the Base Plan has lower coinsurance, a lower calendar year maximum, and a lower orthodontia maximum.

SERVICES	DELTA DENTAL PAYS*		
This list is not an exhaustive list of services.	DELTA DENTAL PPO PROVIDER	DELTA DENTAL PREMIER PROVIDER	OUT OF NETWORK
Diagnostic & Preventive			
Oral examinations, cleanings, x-rays, fluoride treatments, sealants	100%	70%	70%
Basic Services			
Restorative (fillings), general anesthesia, simple extractions, space maintainers	70%	70%	70%
Major Services			
Periodontic Therapy *treatment of gums and bones supporting teeth*	50%	50%	50%
Endodontic Therapy *Root canal therapy*	50%	50%	50%
Complex Oral Surgery	50%	50%	50%
Complex Restorations & Related Services *Crowns, bridges, dentures, injectable antibiotics, harmful habit appliances*	50%	50%	50%
Orthodontic Services			
Straightening of teeth for dependents to age 26	50%	50%	50%
Maximums			
Calendar Year – Per Person *Excludes Orthodontics*	$1,500	50%	$500
Lifetime Orthodontics	$1,000	50%	$500
Annual Deductible			
Per Person Family	Not Applicable	$100 $300	$100 $300

* You are not responsible for charges exceeding the maximum plan allowance (MPA) if you go to a participating Delta Dental dentist. You are responsible for charges exceeding the MPA if you go to a non-participating dentist. The MPA charges are based on fees charged in your geographic area.

Traditional Plan:

Your dental services are most cost effective when visiting an in network provider. You may seek services through non network providers, but you may be balance billed for your services. Balance billing means the provider may charge you the difference between the cost of the service and the allowed amount that Delta Dental will pay.

The Traditional plan excludes diagnostic and preventive services from your annual calendar year maximum, allowing the entire annual maximum to apply to basic and major services. The Traditional plan has a deductible applied for in network services, higher coinsurance, a higher annual maximum, and a higher lifetime maximum on orthodontia.

SERVICES	DELTA DENTAL PAYS*		
This list is not an exhaustive list of services.	DELTA DENTAL PPO PROVIDER	DELTA DENTAL PREMIER PROVIDER	OUT OF NETWORK
Diagnostic & Preventive			
Oral examinations, cleanings, x-rays, fluoride treatments, space maintainers, sealants	100%	100%	80%
Basic Services			
Restorative (fillings), general anesthesia, simple extractions, one occlusal guard every 36 months	80%	80%	80%
Periodontic Therapy *treatment of gums and bones supporting teeth*	80%	80%	80%
Endodontic Therapy *Root canal therapy*	80%	80%	80%
Complex Oral Surgery	80%	80%	80%
Major Services			
Complex Restorations & Related Services *Crowns, bridges, dentures, injectable antibiotics, harmful habit appliances*	50%	50%	50%
Orthodontic Services			
Straightening of teeth for dependents to age 26	50%	50%	50%
Maximums			
Calendar Year – Per Person *Excludes Preventive & Diagnostic Services and Orthodontics*	$2,000		
Lifetime Orthodontics	$2,000		
Annual Deductible			
Per Person Family	$50 $150		
Deductible excludes Diagnostic & Preventive and Orthodontic Services			

* You are not responsible for charges exceeding the maximum plan allowance (MPA) if you go to a participating Delta Dental dentist. You are responsible for charges exceeding the MPA if you go to a non-participating dentist. The MPA charges are based on fees charged in your geographic area.

To find a Delta Dental Provider, Visit Delta's website at www.DeltaDentalTN.com or call the customer service hotline at 800-223-3104.

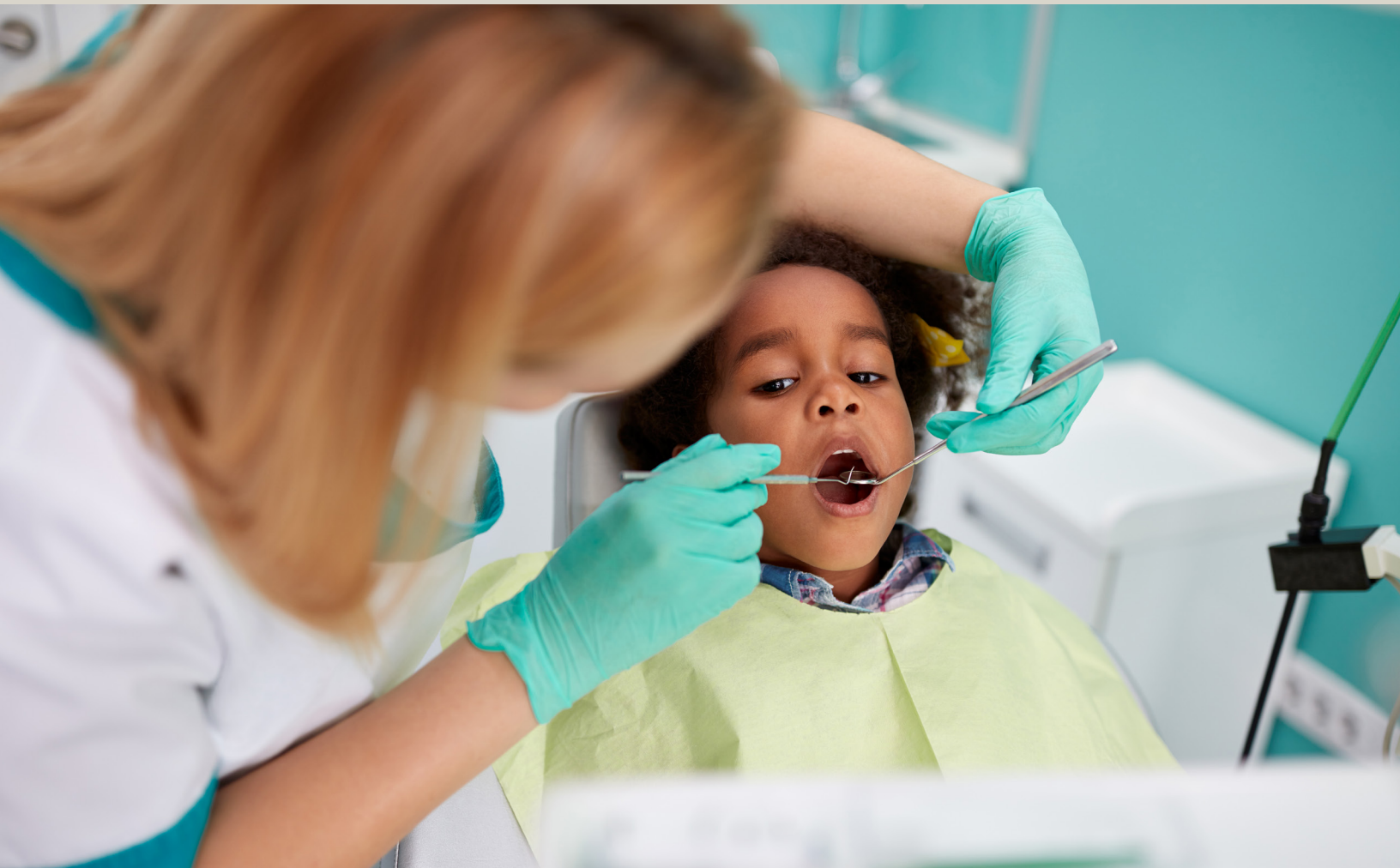
If you remain in the same plan for the 2023 plan year, you may continue to use the same ID card. New enrollees will receive a new ID card from Delta Dental.

You may view your benefit details online using Delta's Consumer Toolkit. Review claims, amounts allocated toward your annual maximum, print ID cards and more. Visit www.DeltaDentalTN.com and select the login for Subscribers.

YOUR 2023 DENTAL PLAN COSTS

Monthly dental premiums are as shown:

	Base Plan	Traditional Plan
Employee	$5.62	$19.39
Employee + 1 Dependent	$11.16	$41.05
Family	$19.98	$79.49



VISION CARE

VSP will continue to be the provider of vision coverage for 2023. It is most cost effective to visit providers within the VSP network. However, if you choose to seek services from an out of network provider, you will receive reimbursements as outlined below.

SERVICES	IN NETWORK	OUT OF NETWORK REIMBURSEMENT AMOUNT
EXAMINATIONS Once Every Calendar Year	Covered 100% After $10 copay	Up to $45
LENSES Once Every Calendar Year	Standard Glass or Plastic Covered 100% After $25 copay Standard progressive $0 Premium progressive $95-105 Custom progressive $150-175	Single Vision Up to $30 Bi-focal Up to $50 Tri-focal Up to $65 Progressive Up to $50
FRAMES Once Every Calendar Year	Covered up to $150 (20% discount off remaining balance over $150 allowance) $80 Costco frame allowance $150 Walmart/Sam's Club frame allowance	Up to $70
DIABETIC EYECARE PLUS PROGRAM As Needed	Services related to diabetic eye disease, glaucoma, retinal screening for eligible members, age-related macular degeneration (AMD), and more $20	Call member services 800-877-7195
CONTACT LENSES* Once Every Calendar year In lieu of Eyeglasses (Frame & Lenses)	Covered up to $150 Retail Allowance – No Copay (Mail in rebate savings on eligible Bausch &Lomb contacts)	Up to $105

*Contact lens exam (fitting and evaluation) are covered in full after copay. Member receives 15% off contact lens exam.
NOTE: If covered participants choose extra options, they are responsible for the additional cost of the options paid directly to the provider.

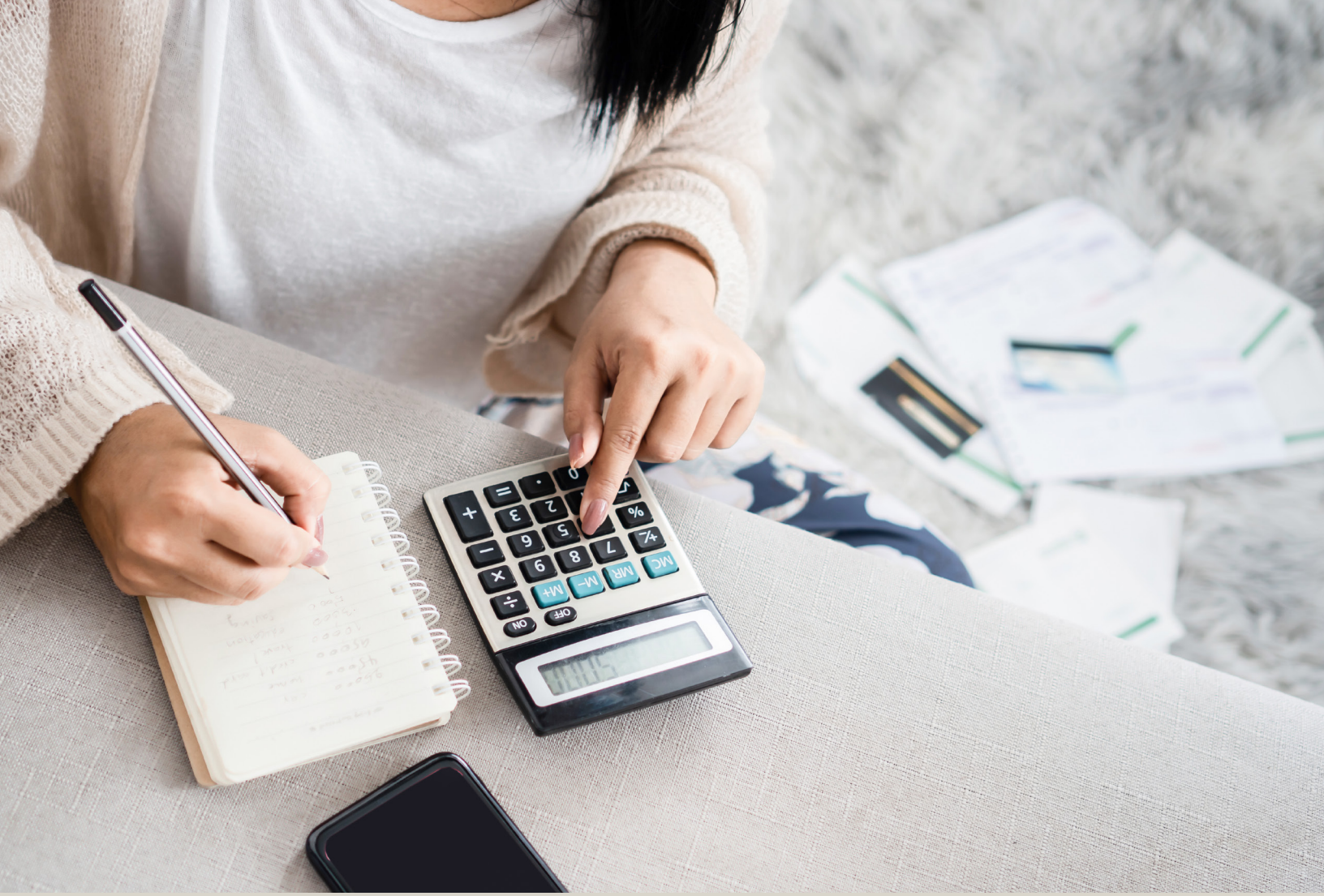
Please refer to your summary plan description for detailed schedule of benefits.

To search for a participating provider, please visit www.vsp.com or call VSP Customer Service at 1-800-877-7195 for assistance.
Please be aware that VSP does not distribute ID cards. *At VSP's website you can register to view claims history, view eligibility and specific plan design, nominate your provider for the network, and print ID cards.*

YOUR 2023 VISION PLAN COSTS

Monthly vision premiums are as shown:

	Vision Plan
Employee	$7.90
Employee + 1 Dependent	$15.80
Family	$26.11



SPENDING ACCOUNTS

FSAs

FLEXIBLE SPENDING ACCOUNTS

A FLEXIBLE SPENDING ACCOUNT (FSA), ALSO KNOWN AS A FLEXIBLE SPENDING ARRANGEMENT, IS ONE OF A NUMBER OF TAX-ADVANTAGED FINANCIAL ACCOUNTS.

Health Care Flexible Spending Account

("Health Care FSA")

The Health Care FSA allows employees to set aside a portion of their annual earnings on a pre-tax basis to pay for many of their out-of-pocket health care expenses for themselves and their dependents.

Each employee's Health Care FSA is funded exclusively through his or her employee salary reduction contributions. ***The maximum amount that can be contributed annually to the Health Care FSA is $2,850**.***

The Patient Protection and Affordable Care Act (PPACA) limits the amount of contributions to each employee's Health Care FSA to $2,850.

Under federal tax law, employees can use the amounts in their Health Care FSA to pay for most unreimbursed medical, dental, vision, hearing, and prescription drug expenses incurred by themselves and their dependents. FSAs have been expanded to cover some over-the-counter medicines (with a valid prescription) like acid controllers, allergy medicines, pain relievers. To find the latest list of eligible expenses, visit IRS.gov. You can access your FSA anytime by visiting myuhc.com.

Dependent Care Flexible Spending Account

("Dependent Care FSA")

The Dependent Care FSA allows employees to set aside a portion of their annual earnings on a pre-tax basis to pay for certain dependent care expenses.

Each employee's Dependent Care FSA is funded exclusively through his or her employee salary reduction contributions. ***The maximum amount that can be contributed annually to the Dependent Care FSA is $5,000. (The maximum amount is less than $5,000 for married employees filing separate tax returns and for employees or spouses who have earned income less than $5,000. Contact the plan administrator for more details.)***

There are several requirements that apply to the use of Dependent Care FSAs. Generally, expenses for the care of an employee's dependents are reimbursable under a Dependent Care FSA only if that care allows the employee, and the employee's spouse (if the employee is married), to work. However, if the employee is married and his or her spouse goes to school full-time at least five months a year or is disabled, expenses for the care of the employee's dependents can be reimbursed through a Dependent Care FSA.

Note: Solely for the purposes of the Dependent Care FSA, the term "dependent" shall mean a "qualifying individual" as defined in Internal Revenue Code § 21(b)(1). Basically, this means a dependent is:

- a child under the age of 13 who is a relative or family member of the employee and for whom the employee is entitled to a deduction on his or her federal income tax return,
- a relative or family member of the employee who is not capable of taking care of themselves, or
- a spouse of the employee who is not capable of taking care of himself or herself.

There are special rules regarding reimbursements under a Dependent Care FSA for dependent care services provided outside the employee's home. Dependent care services provided outside the employee's home are reimbursable only if the dependent is under the age of 13 or regularly spends at least 8 hours each day in the employee's home. Also, expenses for services that are primarily educational rather than for custodial care (e.g., kindergarten tuition) are not reimbursable under a Dependent Care FSA.

United Healthcare administers the FSA. You may create a login with UHC at myuhc.com.

IMPORTANT FSA REMINDERS

Because of their tax-favored status, federal tax law imposes certain rules on reimbursements from the Health Care FSAs or the Dependent Care FSA.

1

Be sure to estimate your expenses carefully. Under federal tax law, FSAs are required to follow a "use it or lose it" rule. That is, any amounts remaining in your FSAs that are not used to reimburse expenses incurred during the Plan Year will be forfeited.

2

The Plan Year begins January 1, 2023 and the grace period for 2023 claims ends on **March 15, 2024.**

3

You have until March 31, 2024 to submit for reimbursement any expenses incurred during the plan year. **Any amounts remaining in your FSA after March 31, 2024 will be forfeited.**

4

To reimburse expenses through an FSA, you must provide evidence that the expenses were *incurred* in the current Plan Year, regardless of when paid. Acceptable forms of evidence include:

a. A provider's statement that shows when the medical expense was incurred and the amount of the expense, or

b. An explanation of benefits from the insurance carrier.

HSAs

HEALTH SAVINGS ACCOUNTS

YOU CAN THINK OF YOUR HEALTH SAVINGS ACCOUNT AS A PERSONAL SAVINGS ACCOUNT FOR YOUR HEALTH CARE EXPENSES, WITH SOME IMPRESSIVE TAX ADVANTAGES

This section only applies to you if you have elected the High Deductible Health Plan.

What Is an HSA?

An HSA is like an individual retirement account for health care expenses. HSAs are individually-owned accounts that accumulate interest, earn investment returns, and have an annual maximum contribution limit set by the IRS. HSA withdrawals are not taxable when used for qualified medical expenses.

How do I know if I am eligible?

To be eligible for an HSA, you must be covered by a HDHP and have no other non-HDHP insurance. The $1,500 deductible plan offered by GAUMC is HSA eligible. It's your responsibility to make sure you're not covered under any other plans that don't meet the IRS rules for HDHPs. This includes coverage through your spouse (including a health flexible spending account, FSA, established by your spouse which could be used to reimburse your medical expenses and would also include Medicare). If the health FSA balance is exhausted as of 12/31/2022, these special rules do not apply.

Who can contribute to the HSA?

As the owner, you can make contributions to your HSA just like you make deposits into a regular savings account. Your employer and family can also contribute funds – and you still get the tax benefits. You usually can make deposits with pre-tax dollars through payroll deductions. Even if you don't use pre-tax payroll deductions, you can deduct contributions to your HSA from your taxable income when you file your income taxes.

Does my employer contribute to my HSA?

Yes, GAUMC will contribute $500 at the beginning of the plan year when you open or already have an existing Optum Bank HSA accoount. Employees hired throughout the year will receive prorated employer contributions. Employees hired between April 1st and June 30th will receive $375. Employees hired between July 1st and September 30th will receive $250. Employees hired between October 1st and December 31st will receive $125.

If I'm over 65 and enrolled in Medicare can I contribute?

It depends. If you enroll in Medicare Part A, or any part of Medicare, you can no longer contribute funds to a Health Savings Account (HSA) without incurring tax penalties. You can decline Medicare Part A as long as you are still working. If you've declined Medicare, you may continue to contribute to an HSA as long as you meet all other eligibility requirements.

What is the contribution limit?

Each year, the federal government sets contribution limits for HSAs. For 2023, you cannot put more money into the HSA than the allowed maximum contribution of $3,850 for individual coverage or $7,750 for family coverage. In addition, individuals age 55 or older may make additional catch-up contributions of up to $1,000. Keep in mind you can change the amount you contribute to your HSA at any time during the year.

Do I have to use all the funds in one year?

No. **The HSA dollars are yours to keep. Unlike an FSA, the dollars will remain in your account and roll over year after year.** You decide how they are invested (within the HSA investment menu), you spend them when and how you want, and you have to keep track of them.

Can I only use the money for qualified medical expenses?

If you are ever in a jam financially and you need to pull out your money for a non-medical expense, you can access your HSA money. You will pay income tax on the amount and probably a penalty. If you are 65 or older or disabled, you are not liable for the penalty.

What are qualified medical expenses?

Qualified medical expenses are defined as medical copayments or coinsurance, long-term care costs, dental care costs, vision care costs, prescription medications, and some over-the-counter medications. HSA funds can also be used to pay for some health care premiums, including COBRA, long-term care, or post-65 retiree medical insurance premiums (though not Medicare supplement plans).

What are the benefits of an HSA?

The funds deposited into an HSA are tax-free in three ways: contributions into the account are excluded from your taxable income; interest you earn on your HSA balance isn't taxed; and as long as you spend the money on qualified medical expenses, spending is tax-free, too! The money in your HSA accumulates interest and grows tax-free, so it's a cost effective way to save.

When you are covered under an HDHP, the money you have accumulated in your health savings account can be used to pay your deductible.

Remember, you are eligible to deposit funds in an HSA only if you are not covered by another health plan. Other health plans would include unspent balances in a flexible spending account that can be used to cover expenses incurred after January 1, 2023. Other health plans would also include Medicare and any plan your spouse has through another employer that covers you, including a health flexible spending account established through your spouse's employer. If the health FSA balance is exhausted as of 12/31/2022 or if the health FSA is designed to cover only dental or vision expenses, these special rules do not apply.

How is a health savings account set up?

Optum Bank offers a range of tools and services that make managing your health savings account easy. They provide live assistance at 800-791-9361. You can also setup online access at www.optumbank.com.

Employees selecting an HSA for the first time have 4 pay periods during which to open their HSA account. If the employee has not opened their account within 4 pay periods after selection of the benefit, the employee forfeits the employer contribution.

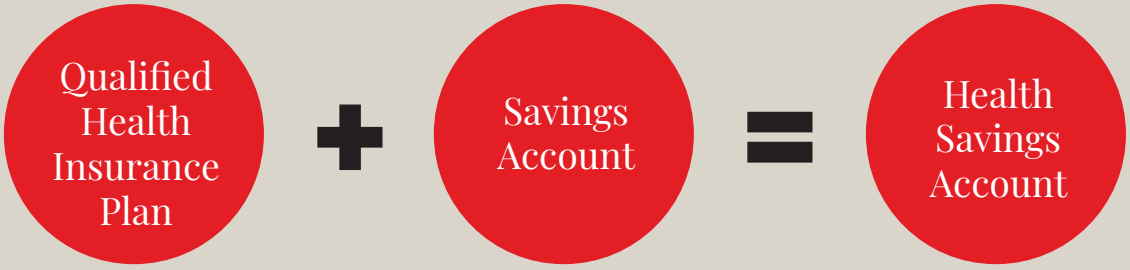
Are there any fees?

Yes, please see the fee schedule below and refer to the Optum Bank website for possible additional fees.

$1.00 per account per month if the balance drops under $500

$3.00 per account per month Investment Fee

$2.50 ATM fee per transaction



DISABILITY INCOME BENEFITS

GAUMC provides full-time employees* with disability income benefits and pays the full cost of this coverage. In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income.

*See page 3 for definition of full-time employee.

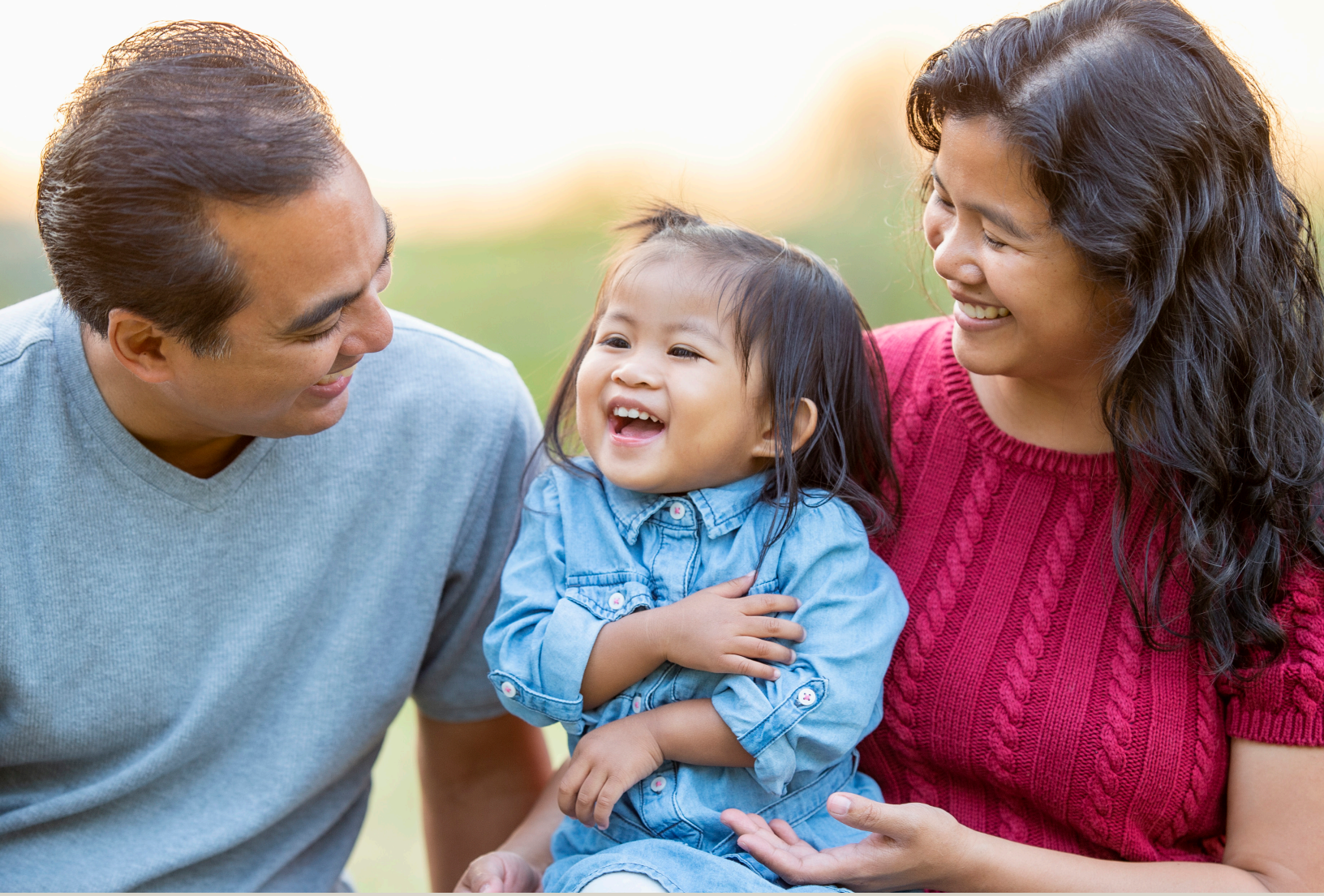
SHORT-TERM DISABILITY

(Self-Insured)

This employer paid benefit is also known as Category B Sick Leave. It is for an employee's long-term illness or short-term disability. Employees accrue 44 working days per year of Category B sick leave at the rate of 3.66 days per month to a maximum of 130 working days (26 weeks). Unused Category B sick days on December 31 can be carried over to the following year. If an employee's illness is expected to exceed 26 weeks, the employee should file for Long Term Disability (LTD) benefits. Check your Policies and Procedures manual for details.

LONG-TERM DISABILITY INSURANCE

In the event of a long term personal illness or injury, GAUMC employees are provided 60% of their salary to a maximum of $6,000 per month until retirement or until employee is deemed eligible to return to work. Check your Policies and Procedures manual for details.



LIFE INSURANCE

KNOW YOUR OPTIONS

Your family depends on your income for a comfortable lifestyle and for the resources necessary to make their dreams – such as a college education – a reality. Like anyone, you don't like to think of the scenario where you're no longer there for your family. However, you do need to ensure their lives and dreams can continue if the worst does happen.

Basic Life Insurance

GAUMC provides full-time employees with basic term life insurance coverage at no cost to you. This benefit has a reduction clause effective at age 65 and again at age 70.

Lay Employees: 2 times annual salary to a maximum of $100,000

Clergy Employees: 2 times annual salary to a maximum of $100,000 less the Comprehensive Protection Plan (CPP) Benefit ($50,000)

Supplemental Group Term Life Insurance

You may also choose to purchase supplemental life insurance coverage in addition to the company-paid benefit. This is a voluntary employee paid plan. The plan pays a benefit in the event of the death of a covered member. Benefit amounts are available in $10,000 increments, up to $500,000, **not to exceed 5 times your annual salary. Employees who do not elect Supplemental Life during their first 30 days of employment, must complete Evidence of Insurability forms when enrolling for any amount of coverage in the plan.** A guaranteed issue amount of $200,000 applies to new hires only. Please see your Human Resources department with any questions about enrolling, terminating or modifying your coverage. This benefit has a reduction clause effective at age 65 and again at age 70.

Your 2023 Supplemental Life Costs

To calculate your premium, use the chart below. Choose your desired coverage level and divide by 1000. Multiply the result by the multiplier in the third column to get your monthly premium.

Lower Age Limit	Upper Age Limit	Multiplier
0	24	0.0600
25	29	0.0700
30	34	0.0900
35	39	0.1000
40	44	0.1200
45	49	0.2000
50	54	0.3500
55	59	0.6600
60	64	0.8900
65	69	1.4100
70	99	3.2000

***DEPENDENT COVERAGE**

You must apply for the same option for both your spouse and children.

Option A (Monthly Premium: $11.25)
Spouse: $25,000
Child - Birth up to age 26: $10,000

Option B (Monthly Premium: $4.00)
Spouse: $10,000
Child - Birth up to age 26: $5,000

*Please be aware that the guaranteed issue amount of $25,000 applies only to those employees who elected Dependent Life Coverage during their initial 30 day new hire enrollment period. Those employees enrolling in Dependent Life Coverage for the first time during an annual enrollment period must complete Evidence of Insurability forms for their dependents and submit to the insurance company for approval before payroll deductions can begin.

Accidental Death & Dismemberment

This is a voluntary employee paid plan with optional family coverage. If you select family coverage, the coverage amount you select applies to both you the employee and to your family. You cannot have a different coverage amount on your family than you have on yourself. The plan pays a benefit in the event of an accidental death following an injury (exclusions apply), or accidental dismemberment following an injury (reduction percentages apply). Benefit amounts are available in $10,000 increments up to $600,000, not to exceed 10 times your annual salary. This benefit has a reduction clause effective at age 65 and again at age 70.

Monthly accidental death and dismemberment premiums are as shown:

Employee only: $0.27/10,000 unit of coverage

Employee plus family: $0.41/10,000 unit of coverage

VOLUNTARY BENEFITS

Other Voluntary Benefits: Accident and Critical Illness (Unum)

Accident and Critical Illness plans are voluntary, employee-paid plans. These plans help to support your out of pocket cost by providing reimbursements paid directly to you depending on the qualified event.

CRITICAL ILLNESS WITH CANCER

- Lump sum benefit based on employee choice of $10,000 or $15,000.
- Benefit is payable at time of diagnosis.
- Employee and spouse premium is based on age rates.
- Guaranteed issue amount up to $15,000.
- Illnesses include heart attack, stroke, organ failure, blindness, cancer plus multiple other illnesses.
- 12-month pre-existing clause applies.
- Spouse ($5,000) and child coverage (25% of employee amount) available.

ACCIDENT

- Lump sum benefit check payable to employee per covered accident.
- Wide range of benefit payouts (including dislocation, burns, ambulance ride, laceration, hospital admission, etc.).
- All coverage guaranteed issue; rates do not increase with age.
- Optional $200 per day sickness hospital confinement.
- Full family coverage available.

Critical Illness and Accident coverage each include a $50 wellness benefit pending completion of an annual wellness screening. All coverage is portable, which means you can take it with you if you terminate employment through GAUMC.

YOUR 2023 CRITICAL ILLNESS COSTS

Monthly costs include Be Well benefit of $50				
Issue Ages	Employee $10,000 Spouse 50% Child 25%		Employee $15,000 Spouse 50% Child 25%	
	Employee only or Employee + Children	Employee + Spouse or Employee + Family	Employee only or Employee + Children	Employee + Spouse or Employee + Family
Under 25	$3.48	$6.06	$4.38	$7.41
25-29	$4.28	$7.26	$5.58	$9.21
30-34	$5.38	$8.91	$7.23	$11.69
35-39	$6.98	$11.31	$9.63	$15.29
40-44	$9.28	$14.76	$13.08	$20.46
45-49	$12.48	$19.56	$17.88	$27.66
50-54	$16.68	$25.86	$24.18	$37.11
55-59	$22.78	$35.01	$33.33	$50.84
60-64	$32.18	$49.11	$47.43	$71.99
65-69	$46.88	$71.16	$69.48	$105.06
70-74	$71.68	$108.36	$106.68	$160.86
75-79	$103.38	$155.91	$154.23	$232.19
80-84	$147.28	$221.76	$220.08	$330.96
85+	$234.88	$353.16	$351.48	$528.06

Rate is based on employee or spouse age; Child(ren) are automatically covered with employee coverage, if applicable. The child benefit amount is 25% of employee coverage amount.

YOUR 2023 ACCIDENT COSTS

	Monthly Premium WITHOUT $200/ day sickness hospital confinement benefit	Monthly Premium WITH $200/day sickness hospital confinement benefit
Employee	$17.78	$22.36
Employee + Spouse	$29.30	$38.46
Employee + Children	$32.08	$41.62
Employee + Family	$43.62	$57.74

Identity Theft Insurance

Identity Theft Insurance is available to you through Allstate Identity Protection. Your identity is made up of more than your Social Security number and your bank accounts. Allstate Identity Protection provides a comprehensive identity protection plan.

- Run your personalized Allstate Digital Footprint and see your digital exposure
- Monitor your credit scores and reports
- Monitor linked social media accounts
- Opt out of telemarketing calls
- Get reimbursed for stolen 401(k) & HSA funds *see the policy for terms, conditions and exclusions.

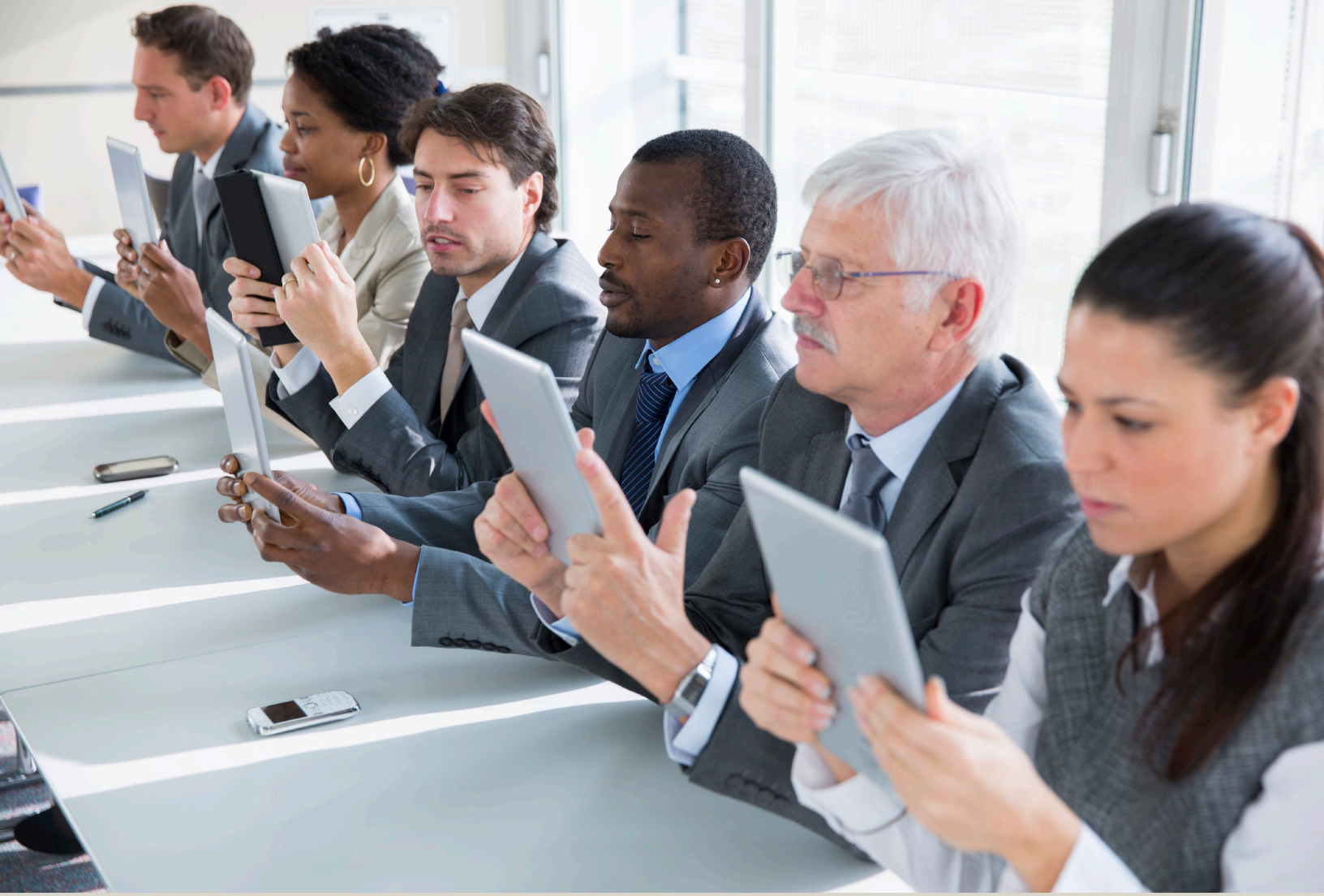
Allstate Identity Protection safeguards your personal information, the data you share, and the relationships you treasure. Enrolled employees and dependents must have a Social Security number to be monitored. There is no age limit for enrolled family members.

Coverage is $9.95 per month for employee only coverage and $17.95 per month for family coverage.

Legal Services Insurance

Legal Services Insurance is available to you through ARAG. Legal coverage isn't just for the serious issues, it's for your everyday needs too. Legal insurance helps you address common situations like creating wills, transferring property, or buying a home. When you work with a network attorney, attorney fees are 100% paid-in-full for most covered matters. ARAG has more than 14,000 attorneys in their network with an average of 20 years of experience.

ARAG's UltimateAdvisor plan is $20.75 per month for you and any of your family members.



Employee Assistance Program (EAP)

GAUMC provides an Employee Assistance Program to all employees of GAUMC and their families. This benefit can be accessed by making a phone call or logging onto a private, secure website. Use of the benefit is free, voluntary, and strictly confidential.

EAP provides the following invaluable benefits, many at no cost to you and your family:

- Managing stress
- Legal and financial concerns
- Finding childcare and elder care
- Grief, depression, substance abuse issues

EAP Specialists are available by telephone 24/7, and can help direct you to a provider for an in-person consultation.

- 866-248-4094
- www.liveandworkwell.com (access code: GAUMC)

WELLNESS PROGRAMS

GAUMC is committed to your health and well-being. Managing your own health and wellness routine is important to all of us. Through various wellness initiatives and resources, staff and family members gain knowledge and increase their ability to manage their health and prevent diseases. You can set your own personal health and wellness goals through UMCWell to lead a healthier lifestyle and to earn wellness incentives.

Rally Rewards Program through United Healthcare

Rally Rewards Program is available to employees and their spouses enrolled in the UHC medical plan. It is an online platform designed to help you make changes to your daily routine, set smart goals, and track progress. Members can access the Rally Rewards platform through myuhc.com or on the Rally mobile app. **Employees and their spouses can earn wellness incentives of a maximum of $300 each per year by completing the tasks listed below. In order to receive any of the incentives, you must complete the online health assessment (survey) first. Completion Timeframe - January 1st – September 30th each year.**

- Annual Wellness Exam - $150
- Online Health Survey - $25
- Completion of Personal Health Action – $125
- Completion of Real Appeal sessions - $125
- Rally Stride (steps tracking) - $20/month

For more information, please contact your Human Resources department.

Real Appeal through United Healthcare

Real Appeal is a program designed to give participants the tools they need to kick-start their weight loss journey. Real Appeal is provided at no additional cost for eligible employees and spouses with a BMI of 23 or higher as a part of their medical plan through United Healthcare.

Livongo for Diabetes Program

Livongo creates personalized experiences, using data science, that delivers positive health outcomes and lowers costs.

24/7 SUPPORT

Certified Diabetes Educators assist to make better diabetes management decisions via real-time support minutes after a high or low blood glucose reading from your Livongo meter. It also provides unlimited scheduled coaching.

DATA DRIVEN INSIGHTS

Our reinforcement learning algorithms deliver trends and customized insights to members through their meter, mobile app, and personal account.

CONNECTED CARE

Livongo creates a better experience for members, their family, friends, and clinicians by allowing for seamless sharing of data.

UNLIMITED STRIPS

Members get as many test strips as needed, when needed, delivered right to their door.

REAL APPEAL INCLUDES:

SUCCESS

A SUCCESS KIT

Nutrition and fitness guides, pedometer, workout DVDs, blender for making healthy smoothies, and more.

COACH

A PERSONALIZED COACH

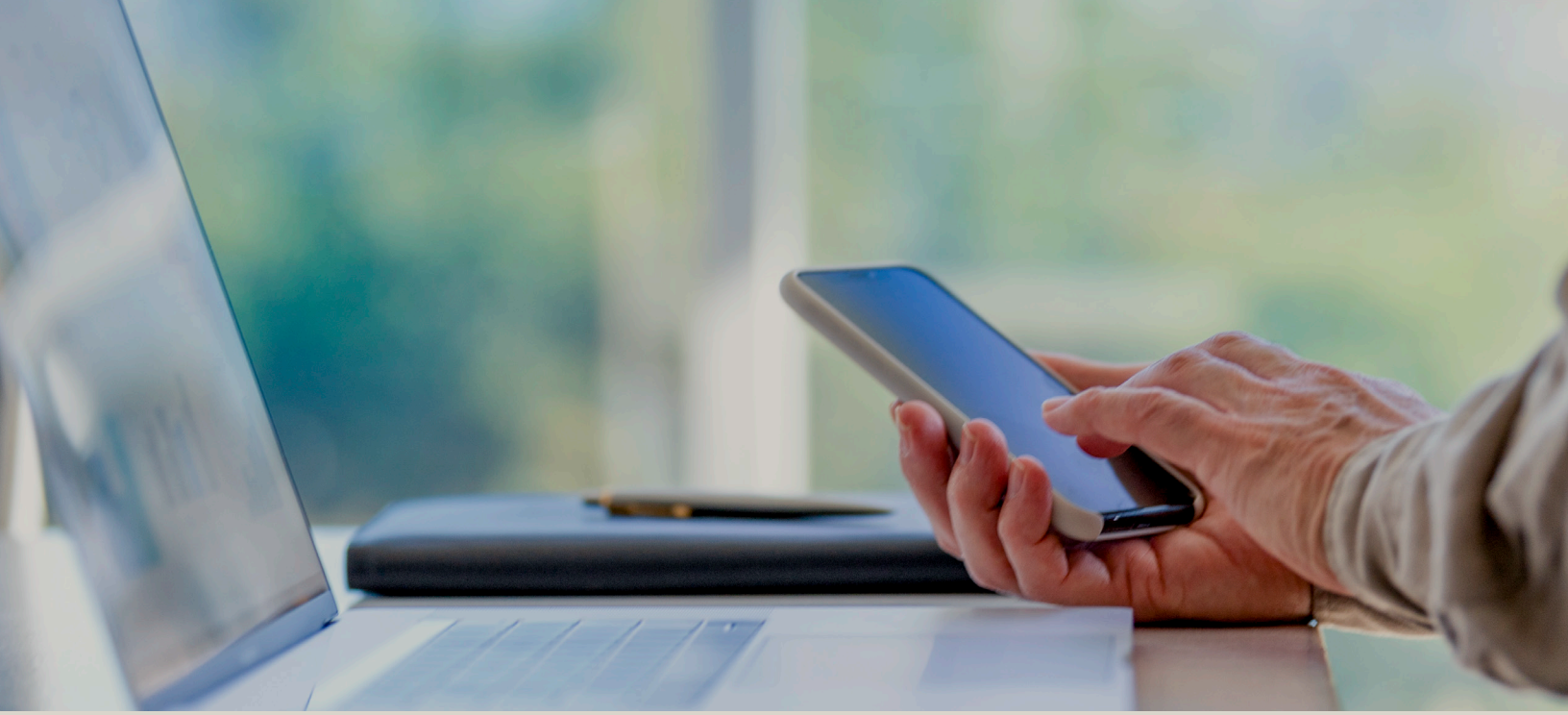
An entire year of personalized coaching based on your goals, medical history, and personal preferences.

SUPPORT

24/7 SUPPORT AND APP

Stay on track with customizable trackers, group support, and access to unlimited digital content.

To enroll, go to generalagency.realappeal.com



CONTACT INFORMATION

BENEFIT PLAN	PROVIDER	TELEPHONE	WEBSITE
Medical	United Healthcare	866-270-5311	www.myuhc.com
Pharmacy	Express Scripts	866-544-1804	www.express-scripts.com
Dental	Delta Dental	800-223-3104	www.DeltaDentalTN.com
Vision Care	VSP	800-877-7195	www.vsp.com
Health Savings Account	Optum Bank	800-791-9361	www.OptumBank.com
Flexible Spending Account	United Healthcare	866-755-2648	www.myuhc.com
Employee Assistance Program	United Healthcare	866-248-4094	www.liveandworkwell.com (access code: GAUMC)
Family Medical Leave (FMLA)	Lincoln Financial	800-291-0112	www.mylincolnportal.com (company code: GAUMC)
Critical Illness and Accident	UNUM	866-679-3054	www.unum.com/employees
Identity Theft	Allstate Identity Protection	800-789-2720	www.myaip.com
Legal Services	ARAG	800-247-4184	www.ARAGlegal.com/myinfo (access code: 18588gau)
Rally Wellness Program	United Healthcare	866-270-5311	myUHC.com
Real Appeal Weight Loss Program	United Healthcare	844-344-7325	generalagency.realappeal.com
Livongo Diabetes Program	Livongo	800-945-4355	livongo.com/GAUMC

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by United Healthcare and GAUMC. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

GLOSSARY

GLOSSARY OF HEALTH COVERAGE AND MEDICAL TERMS

ALLOWED AMOUNT
The maximum payment the plan will issue for a covered health care expense. May also be called "eligible expense", "payment allowance", or "negotiated rate."

BALANCE BILLING
When a provider bills you for the balance remaining on the bill that is not covered by your plan. This amount is the difference between the actual billed amount and the allowed amount.

CLAIM
A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items you think are covered.

COINSURANCE
Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe.

COPAYMENT
A fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of service.

DEDUCTIBLE
An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to almost all covered items and services, and there may be separate deductibles that apply to specific groups or services.

DIAGNOSTIC TEST
Tests to figure out what your health problem is.

EMERGENCY MEDICAL CONDITION
An illness, injury, symptom (including severe pain) or condition severe enough to risk serious danger to your health if you don't get medical attention right away.

EMERGENCY ROOM CARE / EMERGENCY SERVICES
Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse.

EXCLUDED SERVICES
Services that your plan doesn't pay for or cover.

FORMULARY
A list of drugs your plan covers. A formulary may include your share of the cost for each drug and may have different cost sharing levels for each tier.

HOSPITALIZATION
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

HOSPITAL OUTPATIENT CARE
Care in a hospital that usually doesn't require an overnight stay.

IN-NETWORK COINSURANCE
Your share of the allowed amount for covered healthcare services. It is typically lower for in-network covered services.

IN-NETWORK COPAYMENT
A fixed amount you pay for covered health care services to providers who contract with your health insurance or plan. These are typically less than Out-of-Network copayments.

MEDICALLY NECESSARY
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms.

NETWORK
The facilities, providers, and suppliers your health insurance or plan has contracted with to provide health care services.

NETWORK PROVIDER (PREFERRED PROVIDER)
A provider who has a contract with your health insurer who has agreed to provide services to members of a plan. You will pay less if you see a provider In-Network.

OUT-OF-NETWORK COINSURANCE
Your share of the allowed amount for covered health care services to providers who do not contract with your health insurer or plan. Out-of-Network coinsurance usually costs you more than in-network coinsurance.

OUT-OF-NETWORK COPAYMENT
A fixed amount you pay for covered health care services from providers who do not contract with your health insurer or plan. Out-of-Network copayments usually are more than in-network copayments.

OUT-OF-NETWORK PROVIDER (NON-PREFERRED PROVIDER)
A provider who doesn't have a contract with your plan to provide services. If your plan covered out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider.

OUT-OF-POCKET LIMIT
The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit never includes your premium.

OUT-OF-POCKET LIMIT MAXIMUM
Yearly amount the federal government sets as the most each individual can be required to pay in cost sharing during the plan year for covered, in-network expenses.

PREAUTHORIZATION
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your plan may require preauthorization for certain services before you receive them, except in an emergency.

PREMIUM
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

PRESCRIPTION DRUG COVERAGE
Coverage under a plan that helps pay for prescription drugs. If the plans formulary uses tiers, prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each tier of covered prescription drugs.

PREVENTIVE CARE
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

PRIMARY CARE PHYSICIAN
A physician, nurse practitioner, clinical nurse specialist or physician assistant as allowed under state law and the terms of the plan, who provides, coordinates or helps you access a range of health care services.

PROVIDER
An individual or facility that provides health care services. The plan may require the provider to the licensed, certified, or accredited as required by state law.

REFERRAL
A written order from your primary care provider for you to see a specialist or get certain health care services. If you don't get a referral first, the plan may not pay for the services.

SPECIALIST
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-specialist is a provider who has special training in a specific area of health care.

SPECIALTY DRUG
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs in the formulary.

URGENT CARE
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

www.UMCWell.org