Jefferson County Health Benefits Program
Schedule of Benefits January 1, 2026

The following summary of benefits is a brief outline of the maximum amounts or special limits that may apply to benefits payable under the Plan. For a detailed description of each covered service, please refer to the Health Benefits Program booklet.

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Hospital/Facility Deductible	Does not apply	Does not apply
Medical/Surgical Deductible per Calendar Year	Does not apply	Does not apply
Major Medical Deductible per Calendar Year	Does not apply	$600 Per Individual $1,200 Per Family
• **Common Accident Deductible**	Does not apply	Family $600 Cumulative for two or more covered family members injured in the same accident. Only expenses due to that accident and applied against the Plan deductible count toward this limit. Expenses also count toward the Calendar Year deductible.
• **Carry-over Individual Deductible**	Does not apply	Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year
• **Network Copayment, per visit Deputies**	$25 for certain Physician visits and outpatient services	$40 for certain Physician visits and outpatient services
	See individual plan features for details. "Per visit" means per Provider per day.	
	Copayments do not apply to the Out-of-Network deductible. Copayments do apply to the Out-of-Pocket Limit.	
• **Network Copayment, per visit All groups except Deputies**	$30 for certain Physician visits and outpatient services	$40 for certain Physician visits and outpatient services
	See individual plan features for details. "Per visit" means per Provider per day.	
	Copayments do not apply to the Out-of-Network deductible. Copayments do apply to the Out-of-Pocket Limit.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
• **Benefit Copayment, per visit All Agencies**	$100 for Emergency Room facility care	
• **Benefit Copayment, per stay All groups except Deputies**	$100 for Inpatient Hospital Facility	
Percentage Coinsurance (See individual plan features for details.) • **Hospital/Facility Benefits**	Plan pays 100% of the allowable network fee for covered services and supplies.	
• **Other Coinsurance**	Medical/Surgical Benefits: The Plan pays 100% of the allowable network fee for covered services and supplies after any applicable copayment.	Major Medical Benefits: The Plan pays 80% of the Usual, Reasonable and Customary charge (URC) for most covered services and supplies after application of the Major Medical deductible and any applicable copayment. The Covered Person pays the remaining 20%.
Medical/Surgical and Major Medical Out-of-Pocket (OOP) Limit, per Calendar Year	When copayment amounts reach the following maximums, no copayment will be required: $6,600 per individual $13,200 per family	Major Medical OOP: $1,350 *including copayments.* However, while copayment amounts apply to the OOP of $1,350, these copayments will continue to apply to services after the OOP is met. Deductible and Prescription Drug copayments are excluded.
Spell of Illness Limit	365 days per Spell of Illness (applies to Hospital inpatient care, including maternity admissions, Mental Health Disorders, Substance Use Disorders, Skilled Nursing Facility Care, Rehabilitation Facility Care, and Home Health Care)	
	A Spell of Illness begins when a Covered Person is admitted to a Hospital or other Covered Facility, Birthing Center, Skilled Nursing Facility, or Rehabilitation Facility or receives Home Health Care. It ends when the Covered Person has not been a patient in a Hospital or other Covered Facility, Birthing Center, Skilled Nursing Facility, or Rehabilitation Facility or received Home Health Care for a period of at least 90 days for the same illness.	
Maximum Benefit Amounts	Lifetime – Unlimited	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
	N/A	Major Medical Benefits per Calendar Year – Unlimited
Benefit Management Services Program/Pre-Notification	This mandatory program requires a phone call before the Covered Person is admitted to a Hospital, or before diagnostic testing is scheduled to be performed in an inpatient setting. Please contact UMR CARE toll-free at 1-866-494-4502. A benefit reduction will be applied for non-compliance with this requirement. Pre-certification is required for the following services: **(1) Inpatient admissions.** Inpatient Hospitalizations except emergency, urgent, and maternity stays Rehabilitation Facility inpatient stays Skilled Nursing Facility inpatient stays Substance Use Disorder/Mental Disorder inpatient admissions Notice of an emergency, urgent, or a maternity stay is requested to review Medical Necessity. **(2) Outpatient Diagnostic Testing Review.** Benefits may be reduced if diagnostic testing is rendered in an inpatient setting.	
☎ = If this Plan is primary, benefits with this symbol require precertification. Call UMR CARE at 1-866-494-4502. See the section entitled Benefit Management Services for details.		

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Acupuncture (based on Medical Necessity for pain relief or in lieu of anesthesia)	100% of the Allowable Fee after network copayment	80% of URC after deductible
Allergy Treatment	Visits and Treatment 100% of the Allowable Fee after a network copayment. Allergy Serum/Preparation Only 100% of the Allowable Fee, copayment does not apply	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	For allergy laboratory testing billed separately, see Diagnostic Testing.	
Ambulance • **Hospital**	100% of the Allowable Fee	100% of URC
Ambulance • **Professional**	100% of the Allowable Fee up to a limit of $50 maximum benefit per trip, then the balance is subject to Major Medical at 80% of URC after deductible.	100% of URC up to a limit of $50 maximum benefit per trip, then the balance is subject to Major Medical at 80% of URC after deductible.
Ambulance • **Volunteer**	100% up to $50 for trips under 50 miles or $75 for trips 50 miles and up.	100% up to $50 for trips under 50 miles or $75 for trips 50 miles and up. The deductible does not apply.
	Hospital, local professional, and volunteer ambulance, train, and air ambulance are covered.	
Ambulatory Surgical Center, Freestanding	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Anesthesia	100% of the Allowable Fee	80% of URC after deductible
	Coverage is also available for administration of anesthesia for non- surgical procedures when found Medically Necessary according to Plan provisions, for example, for covered electroshock therapy.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Biofeedback (based on Medical Necessity for certain medical disorders)	100% of the Allowable Fee	80% of URC after deductible
Blood and Blood Product Services	100% of the Allowable Fee	80% of URC after deductible
Cardiac Rehabilitation • **Freestanding Facility**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Cardiac Rehabilitation • **Outpatient Hospital**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Cardiac Rehabilitation • **Physician Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Chemotherapy • **Freestanding Facility**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Chemotherapy • **Outpatient Hospital**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	Charges for oral chemotherapy and subcutaneous or intramuscular injections are payable as a Medical Surgical / Major Medical Benefit.	
Chemotherapy • **Physician Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Chiropractic Care (manipulation and related X-ray services)	100% of the Allowable Fee after network copayment per visit	80% of URC after deductible
	Subject to medical review; Maintenance Care is not covered.	
Clinical Trials • **Routine Patient Costs**	See specific service type for benefit.	Out-of-Network Providers will be allowed if an In-Network Provider will not accept the patient. See specific service type for benefit.
Consultation • **Inpatient**	100% of the Allowable Fee	80% of URC after deductible
	Limited to one inpatient consult per specialty per confinement for each condition	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Consultation • **Outpatient/Office**	100% of the Allowable Fee	80% of URC after deductible
	Limited to one inpatient consult per specialty per confinement for each condition	
Consultation • **Second Surgical – Voluntary**	100% of the Allowable Fee	80% of URC after deductible
Contact Lenses / Eyeglasses Following Intraocular / Cataract Surgery	100% of the Allowable Fee	80% of URC after deductible
	Benefit includes one pair of eyeglasses or contact lenses plus one exam following surgery.	
Dental Care, Limited	See Plan feature for details.	See Plan feature for details
	Benefits are available for limited oral surgical procedures and for treatment of accidental injury within 12 months of the accident.	
Diabetic Education	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Diabetic Supplies/Equipment	Not a separate benefit. Medically Necessary glucometers and insulin pumps are covered under the "Durable Medical Equipment" benefit. Syringes are covered under the "Medical Supplies (home use)" benefit or "Prescription Drug Benefits". Additional diabetic supplies are covered under your "Prescription Drug Benefits".	
Diagnostic Testing • Independent / Free Standing Laboratory	100% of the Allowable Fee after network copayment	80% of URC after deductible
Diagnostic Testing • Laboratory	100% of the Allowable Fee after network copayment	80% of URC after deductible
Outpatient Hospital (lab, machine, X-ray testing) • **Patient present in the outpatient department**	100% of the Allowable Fee after network copayment	100% of URC after network copayment

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Outpatient Hospital (lab, machine, X-ray testing) • **Patient *not* present in the outpatient department**	100% of the Allowable Fee after network copayment	100% of URC
Outpatient Hospital (lab, machine, X-ray testing) • **Professional Interpretation**	100% of the Allowable Fee	80% of URC
Outpatient Hospital (lab, machine, X-ray testing) • **X-ray**	100% of the Allowable Fee after network copayment	80% of URC
	☎ Benefits may be reduced if diagnostic testing is rendered in an inpatient setting.	
Outpatient Hospital (lab, machine, X-ray testing) • **X-ray**	100% of the Allowable Fee after network copayment	80% of URC
Dialysis • **Freestanding Facility** • **Outpatient Hospital** • **Physician Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Dietary / Nutritional Counseling other than Diabetes	Not Covered. See Preventive Care for wellness benefits	Not Covered. See Preventive Care for wellness benefits
Durable Medical Equipment	100% of the Allowable Fee	80% of URC after deductible
Oxygen	100% of the Allowable Fee	80% of URC after deductible
Breastfeeding Equipment (rental or purchase)	100% of the Allowable Fee	80% of URC after deductible
Electro-shock Therapy	100% of the Allowable Fee	80% of URC after deductible

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Food Products (Aminoacidopathies Formula, Enteral Formulas, Modified Solid Food Products)	100% of the Allowable Fee	80% of URC after deductible
Foot Care and Podiatry Services • **Visit**	100% of the Allowable Fee after network copayment	80% of URC after deductible
Foot Care and Podiatry Services • **Foot Orthotics**	100% of the Allowable Fee	80% of URC after deductible
	Orthotic devices for the feet are not covered unless used as conservative treatment for the back, hips, pelvis, ankle, knee, and legs.	
Foot Care and Podiatry Services • **Surgery**	100% of the Allowable Fee after network copayment	80% of URC after deductible
	Routine foot care is not covered. Exception: Routine foot care is covered for patients with severe systemic disorders, such as diabetes. Charges for orthopedic shoes and other supportive devices are not covered.	
Genetic Testing	See Diagnostic Testing for Benefit	
• **Related Genetic Counseling (see Preventive Care for wellness benefit.)**	100% of the Allowable Fee after network copayment	100% of URC after network copayment Deductible does not apply. Any balance that exceeds the URC is the responsibility of the Covered Member
Hearing Aid and Related Exam	100% of the Allowable Fee	100% of URC The deductible does not apply.
	Limited to $150 in any 36-month period.	
Home Health Care	100% of the Allowable Fee	100% of URC
	Three visits of HHC care count as one Benefit day toward the 365-day Spell of Illness limit. Medical/Surgical and Major Medical Benefits are available after this limit is reached. One HHC Visit equals • Up to four (4) hours of home health aid care; or • Each visit by other covered members of the HHC team. Services must be in lieu of Hospitalization or inpatient SNF care.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Hospice Care	100% of the Allowable Fee	100% of URC
	Benefits are payable for the period the Covered Person is accepted in the hospice care program. Bereavement counseling visits are covered for family members during the Covered Person's illness and until one year after the Covered Person's death.	
Hospital Facility • **Inpatient Hospital**	100% of the Allowable Fee after benefit copayment	100% of URC after benefit copayment
	Limited to 365 days per Spell of Illness. Medical/Surgical and Major Medical Benefits are available after this limit is reached.	
	☎ Room and Board charge limited to actual semi-private or ICU/specialty unit rate. The charge for a private room is based on the average semi-private room rate. A Medically Necessary private room is covered.	
Hospital Facility • **Outpatient Clinic**	100% of the Allowable Fee	100% of URC
	Clinic room only; related services are allowed per service type.	
Hospital Facility • **Emergency Room for Medical Emergency Condition**	For services rendered within 72 hours of an accident or 12 hours of a sudden onset of illness:	
	100% of the Allowable Fee after benefit copayment	100% of URC after benefit copayment
	Benefit copayment is waived if the Covered Person is admitted as an inpatient into the treating Hospital directly from the emergency room.	
Hospital Facility • **Emergency Room for non-Medical Emergency Condition**	Not Covered	Not Covered
Hospital Facility • **Outpatient Surgical Center**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Hospital Facility • **Other Outpatient Hospital Services and Supplies**	See specific service type for benefit.	
Infertility Services • **Basic Services**	See Plan feature for detail. Benefit is limited to the initial evaluation and testing for Infertility.	
Infertility Services • **Advanced Services**	See Plan feature for detail. Benefit is limited to the initial evaluation and testing for Infertility.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
In-Hospital / Facility Physician's Care	100% of the Allowable Fee	80% of URC after deductible
	Coverage is only provided for visits for days approved for a covered inpatient stay.	
IV (Infusion) Therapy • **Outpatient Hospital**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	See also Home Health Care.	
IV (Infusion) Therapy • **Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	See also Home Health Care.	
Maternity Care • **Inpatient Hospital and Certified Birthing Centers**	100% of the Allowable Fee	100% of URC
	Limited to 365 days per Spell of Illness. Medical/Surgical and Major Medical Benefits are available after this limit is reached.	
	☎ Room and Board charge limited to actual semi-private or ICU/specialty unit rate. The charge for a private room is based on the average semi-private room rate. A Medically Necessary private room is covered.	
	Maternity is covered the same as any other Illness.	
Maternity Care • **Prenatal, Delivery, and Postpartum Care of Normal Pregnancy, Physician Charge (Physician / Midwife)**	100% of the Allowable Fee	80% of URC after deductible
	Related testing is covered separately per service type rendered.	
Maternity Care • **Complications of Pregnancy and Termination of Pregnancy, Physician Charge**	100% of the Allowable Fee	80% of URC after deductible
	Related testing is covered separately per service type rendered.	
Medical / Surgical Supplies	100% of the Allowable Fee	80% of URC after deductible
Mental Disorder Treatment • **Inpatient** • **General Hospital, Private Proprietary or Public Psychiatric Facility** • **Hospital Mental Disorder Partial Hospitalization**	100% of the Allowable Fee	100% of URC
	☎ Limited to 365-day limit per spell of illness (applies toward the inpatient Hospital Spell of Illness maximum) Medical/Surgical and Major Medical Benefits are available after this limit is reached. Room and Board charge limited to actual semi-private or ICU/specialty unit rate. The charge for a private room is based on the average semi-private room rate. A Medically Necessary private room is covered.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Mental Disorder Treatment • **Inpatient, Physician Charge**	100% of the Allowable Fee	80% of URC after deductible
Mental Disorder Treatment • **Outpatient / Office**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	Services must be rendered and billed by a New York State licensed mental health professional performing services within the scope of their license (doctor, psychologist, social worker). For services rendered and billed outside of New York State the Provider must be operating within the scope of their license and operating according to the laws of the jurisdiction where the services are rendered. Services billed by a Hospital or a mental health facility, Physician's corporation, or clinic for the services of a similarly licensed Provider will also be covered. Family therapy is covered.	
Mental Disorder Treatment • **Psychological Testing**	100% of the Allowable Fee after a network copayment	80% of URC after deductible
Newborn Care • **Circumcision**	100% of the Allowable Fee	100% of URC The deductible does not apply.
Newborn Care • **Hospital**	See Hospital / Birthing Center	
Newborn Care • **Physician**	100% of the Allowable Fee	100% of URC The deductible does not apply.
	Limited to Allowed Charges made by a Physician for routine pediatric care after birth while the newborn child is Hospital-confined up to four days. If the baby's routine care is extended due to the mother's continued stay, benefits will not be paid even if the mother was needed to provide basic care, such as breastfeeding. Routine newborn care billed by an anesthesiologist or the delivering Physician is not covered.	
Nursing, Private Duty • **Inpatient**	Not Covered	Not Covered

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Nursing, Private Duty • **Outpatient**	100% of the Allowable Fee	60% of URC after deductible
	The first 48 hours of nursing care in a Calendar Year are not covered. Limited to $25,000 per Calendar Year; this limit may be waived, subject to medical review.	
Visiting Nurses	100% of the Allowable Fee	100% of URC
	Part-Time or Intermittent Care is Covered.	
	Charges are covered only when care is Medically Necessary and not Custodial in nature. The charges covered for outpatient nursing care are those shown billed by a certified or licensed visiting nurse agency or by a state or county visiting nurse service for professional nurse services. Outpatient private duty nursing care on a 24-hour-shift basis is not covered	
Obesity, Morbid Treatment	Benefits are based on service type rendered. Medically Necessary (as determined by the Claims Administrator) weight reduction surgery is limited to gastric bypass and lap band procedures. Non-surgical charges for Morbid Obesity will be covered; however, charges for dietary/nutritional counseling are excluded.	
Occupational Therapy • **Freestanding Facility**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Occupational Therapy • **Outpatient Hospital**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Occupational Therapy • **Physician Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Orthotics	100% of the Allowable Fee	80% of URC after deductible
Osteopathic Manipulation	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Physical Therapy • **Freestanding Facility**	100% of the Allowable Fee after network copayment	100% of URC after network copayment

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Physical Therapy • **Outpatient Hospital**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	Treatment must begin within six months and end within 365 days of the date of a related Hospital discharge or date of surgery.	
Physical Therapy • **Office**	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	Maintenance Care is not covered.	
Physician Care • **Emergency Room** • **Medical Emergency**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	Benefit copayment applies if the Covered Person is admitted as an inpatient into the treating Hospital directly from the emergency room.	
Physician Care • **Emergency Room** • **Non-Medical Emergency**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Physician Care • **Office or Home**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Physician Care • **Clinic**	100% of the Allowable Fee after a network copayment	80% of URC after deductible
	Services must be given and billed by a covered healthcare Provider and found Medically Necessary according to Plan provisions in an office, clinic, home, or elsewhere. Outpatient Mental Health Disorder care, outpatient Substance Use Disorder care, outpatient consultations, surgical and obstetrical procedures, rehabilitation therapy, preventive care, and chiropractic care are not covered under this benefit.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Preadmission Testing	100% of the Allowable Fee after network copayment	100% of URC after network copayment
	Must be: • Performed on an outpatient basis within 14 days before a scheduled Hospital surgery; • Your Physician ordered the tests; and • Physically present at the Hospital for the tests. Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.	
Prescription Drugs	See the separate Prescription Drug Expense Benefit (ProAct) below.	
Preventive Care (Includes all Ancillary Charges) • **Routine Adult Physical (from Age 19)**	If a Network Provider is not available, the Plan will benefit 100% of charges and the deductible will not apply.	
	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	The recommendations of the United States Preventive Services Task Force will apply to exams and screening tests; the recommendations of the Advisory Committee on Immunization Practices (ACIP) will apply to immunizations.	Benefit includes routine exam and related screening tests follows the recommendations of the U.S. Preventive Services Task Force. Immunizations: the administration of the vaccine is covered; the charge for the vaccine is excluded.
Preventive Care (Includes all Ancillary Charges) • **Mammography Screening**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Preventive Care (Includes all Ancillary Charges) • **Bone Density Testing**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Preventive Care (Includes all Ancillary Charges) • **Cervical Cancer Screening**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Preventive Care (Includes all Ancillary Charges) • **Prostate Cancer Screening**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Preventive Care (Includes all Ancillary Charges) • **Colorectal Cancer Screening**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Preventive Care (Includes all Ancillary Charges) • **Genetic Counseling / Testing (related to BRCA mutation genetic screening for breast and ovarian cancer)**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	The recommendations of the U.S. Preventive Services Task Force apply.	
Preventive Care (Includes all Ancillary Charges) • **Smoking / Tobacco Use Cessation Counseling**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	The recommendations of the U.S. Preventive Services Task Force apply. Smoking cessation drugs are covered under the Prescription Drug Benefit.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Preventive Care (Includes all Ancillary Charges) • **Nutritional Counseling (for adults with risk factors and both adults and children with obesity)**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	Limited to 26 wellness visits (no more frequently than one visit every two weeks) per Covered Person per Calendar Year combined In-Network and Out-of-Network.	
Preventive Care (Includes all Ancillary Charges) • **Well-Woman Services not otherwise specified**	Women's preventive services under the Affordable Care Act include, but are not limited to, coverage for screening, counseling, and contraception methods; see the Preventive Care section in the SPD for details.	
Preventive Care (Includes all Ancillary Charges) • **HPV-DNA Testing**	100% of the Allowable Fee	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
Preventive Care (Includes all Ancillary Charges) • **Contraception Management**	100% of the Allowable Fee	100% of URC after a network copayment
Preventive Care (Includes all Ancillary Charges) • **Screening for Gestational Diabetes**	100% of the Allowable Fee	80% of URC after deductible
Preventive Care (Includes all Ancillary Charges) • **Breastfeeding Equipment (rental or purchase)**	100% of the Allowable Fee	80% of URC after deductible

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Preventive Care (Includes all Ancillary Charges) • **Well Child Care (up to Age 19)**	100% of the Allowable Fee	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	Coverage for health care visits and related testing follows the recommendations of the U.S. Preventive Services Task Force; the recommendations of the Advisory Committee on Immunization Practices (ACIP) will apply to immunizations. Routine newborn care is covered as shown above.	Immunizations: the administration of the vaccine is covered; the charge for the vaccine is excluded. Coverage for health care visits and related testing follows the recommendations of the U.S. Preventive Services Task Force. Routine newborn care is covered as shown above.
Prosthetics	100% of the Allowable Fee	80% of URC after deductible
Pulmonary Rehabilitation • **Freestanding Facility**	100% of the Allowable Fee	80% of URC after deductible
Pulmonary Rehabilitation • **Freestanding Facility**	100% of the Allowable Fee	80% of URC after deductible
Physician Office	100% of the Allowable Fee	80% of URC after deductible
	Coverage is limited to a maximum of 36 visits per Covered Person per Lifetime for an approved plan of care. Related testing procedures will be considered separately as diagnostic testing. Related Physician exams and evaluations will be considered separately as Physician visits.	
PUVA (Psoralen & Ultraviolet Radiation Light Therapy)	100% of the Allowable Fee	80% of URC after deductible
Radiation Therapy • **Freestanding Facility**	100% of the Allowable Fee	80% of URC after deductible
Radiation Therapy • **Outpatient Facility**	100% of the Allowable Fee after network copayment	100% of URC after network copayment

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Radiation Therapy • **Office**	100% of the Allowable Fee	80% of URC after deductible
Refractive Surgery	Not Covered	Not Covered
Rehabilitation Facility • **Inpatient Services**	100% of the Allowable Fee	100% of URC
	☎ Limited to 365-day limit per Spell of Illness (applies toward the inpatient Hospital Spell of Illness maximum). Two days of care count as one Benefit day. Medical/Surgical and Major Medical Benefits are available after this limit is reached. Room and Board charge limited to actual semi-private or ICU/specialty unit rate. The charge for a private room is based on the average semi- private room rate. A Medically Necessary private room is covered. If the facility qualifies as a SNF, benefits are not available if Medicare is primary or if Medicare benefits for skilled nursing facility care are exhausted.	
Rehabilitation Facility • **Outpatient Services**	See specific service type for benefit. For example, benefits for outpatient services are the same as the benefits for outpatient Hospital diagnostic X-ray, laboratory, pathology, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, radiation therapy, and inhalation therapy services shown in this section.	
Respiratory Therapy • **Freestanding Facility**	100% of the Allowable Fee	80% of URC after deductible
Respiratory Therapy • **Outpatient Hospital**	100% of the Allowable Fee	80% of URC after deductible
Respiratory Therapy • **Physician Office**	100% of the Allowable Fee	80% of URC after deductible

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Skilled Nursing Facility • **Inpatient Services**	100% of the Allowable Fee	100% of URC
	 Limited to 365-day limit per Spell of Illness (applies toward the inpatient Hospital Spell of Illness maximum). Two days of SNF care count as one Benefit day. Medical/Surgical and Major Medical Benefits are available after this limit is reached. Room and Board charge limited to actual semi-private or specialty unit rate. The charge for a private room is based on the average semi- private room rate. A Medically Necessary private room is covered. Benefits are not available if Medicare is primary or if Medicare benefits for skilled nursing facility care are exhausted.	
Skilled Nursing Facility • **Outpatient Services**	See specific service type for benefit. For example, benefits for outpatient SNF are the same as the benefits for outpatient Hospital diagnostic Xray, laboratory, pathology, physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, radiation therapy, and inhalation therapy services shown in this section.	
Smoking Cessation	See Preventive Care.	
Speech Therapy • **Freestanding Facility**	100% of the Allowable Fee	80% of URC after deductible
Speech Therapy • **Outpatient Hospital**	100% of the Allowable Fee	80% of URC after deductible
Speech Therapy • **Physician Office**	100% of the Allowable Fee	80% of URC after deductible
Substance Use Disorder Detoxification / Rehabilitation Treatment • **Inpatient Facility** • **General Hospital or Certified Alcohol / Substance Use Disorder Facility Program** • **Hospital Substance Use Disorder Day / Night Care Center**	100% of the Allowable Fee	100% of URC
	 100% for up to 365 days per Spell of Illness. Limited to 365-day limit per Spell of Illness (applies toward the inpatient Hospital Spell of Illness maximum). Medical/Surgical and Major Medical Benefits are available after this limit is reached. Room and Board charge limited to actual semi-private or ICU/specialty unit rate. The charge for a private room is based on the average semiprivate room rate. A Medically Necessary private room is covered.	

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Substance Use Disorder Detoxification / Rehabilitation Treatment • **Inpatient Physician**	100% of the Allowable Fee	80% of URC after deductible
Substance Use Disorder Detoxification / Rehabilitation Treatment • **Outpatient / Office**	100% of the Allowable Fee after a network copayment.	100% of URC after a network copayment. Deductible does not apply. Any balance that exceeds URC is the responsibility of the Covered Person.
	Family Therapy is covered.	
Surgical Charge Benefit • **Assistant Surgeon**	100% of the Allowable Fee	80% of URC after deductible
Surgical Charge Benefit • **Surgeon** ○ **Inpatient**	100% of the Allowable Fee	80% of URC after deductible
Surgical Charge Benefit • **Surgeon** ○ **Office**	100% of the Allowable Fee	80% of URC after deductible
Surgical Charge Benefit • **Surgeon** ○ **Outpatient**	100% of the Allowable Fee	80% of URC after deductible
	Breast biopsy Bronchoscopy Colonoscopy D&C – diagnostic Excision of skin lesion	Gastroscopy Laparoscopy - diagnostic Myringotomy Vasectomy
	Outpatient: 100% of the Allowable Fee	Outpatient: 100% of URC after deductible
	Inpatient: 100% of the Allowable Fee	Inpatient: 800% of URC after deductible
Therapeutic Injections	100% of the Allowable Fee after network copayment	100% of URC after network copayment
TMJ (temporomandibular joint) Treatment	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Transplants – Organ / Tissue	Covered See Plan features for detail.	

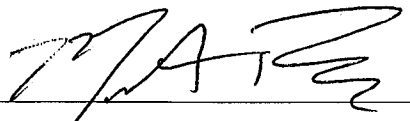
Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits
Urgent Care Facility	100% of the Allowable Fee after network copayment	100% of URC after network copayment
Vision Care	Scheduled benefits for routine vision exams and lenses are offered through the Davis Vision Care Program.	
Vision Therapy (based on Medical Necessity)	100% of the Allowable Fee	80% of URC after deductible
Voluntary or Elective Abortion	Covered- See Plan feature for detail.	Covered- See Plan feature for detail.
Voluntary or Elective Sterilization Procedure	Covered- See Plan feature for detail.	Covered- See Plan feature for detail.
Wigs	Not Covered	Not Covered

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits

Prescription Drug Benefits		
Prescription Drug Benefits" are generally separate from "Medical Benefits" and do not apply to the deductibles, copayments, or Out-of-Pocket limits for Medical Benefits.		
Any one retail Pharmacy prescription or refill is limited to a 90-day supply. Any one mail order prescription or refill is limited to a 90-day supply		
Covered Drugs and Supplies	**In-Network and Out-of-Network**	
Prescription Drug Benefit (ProAct) **Deputies**	**Note:** You must pay applicable copayments*. The Plan pays the balance of Allowable Fees.	
	Copayments Per Prescription	
	Retail	**Mail-Order**
Generic (Tier 1)	$15.00	$15.00
Preferred Brand (Tier 2)	$30.00	$30.00
Non-Preferred Brand (Tier 3)	$50.00	$50.00
Specialty Drugs (Tier 4)	20%	20%
Prescription Drug Benefit (ProAct) **All groups except Deputies**	**Note:** You must pay applicable copayments*. The Plan pays the balance of Allowable Fees.	
	Copayments Per Prescription	
	Retail	**Mail-Order**
Generic (Tier 1)	$15.00	$30.00
Preferred Brand (Tier 2)	$30.00	$60.00
Non-Preferred Brand (Tier 3)	$50.00	$100.00
Specialty Drugs (Tier 4)	20%	20%
Out-of-Pocket Limit	In-Network copayments apply to the Medical/Surgical and Major Medical Out-of-Pocket Limit.	
*The Plan will follow the federal Patient Protection and Affordable Care Act as it pertains to the preventive care provisions of the Plan. Contact ProAct's Customer Service Department toll-free at 1-866-287-9885 for details on medications which do not require a copayment; for example, no copayment applies to certain prescription contraceptives, aspirin, folic acid, fluoride, iron, smoking cessation agents, and Vitamin D.		

Plan Features	In-Network Benefits (POMCO Select/UHC Options PPO)	Out-of-Network Benefits

No patient cost share is required for Generic drugs mandated as covered under this provision. If a Generic version is not available or would not be medically appropriate for the patient as determined by the attending Physician, the Brand Name drug will be available at no cost share, subject to reasonable medical management approval.
IN WITNESS WHEREOF this agreement has been executed on behalf of Jefferson County Employees Health Benefits Program.

By:	
Title:	Director of Insurance
Date:	9/30/2025