



# Side-by-side benefits comparisons at-a-glance: Surest and UnitedHealthcare medical plan options 2025

For eligible active employees, employees on a leave of absence (LOA) or Short-Term Disability (STD),  
and COBRA participants

NOKIA

# Medical

## Surest Enhanced plan options

Please note: For the Surest medical services shown in the table below and on the following pages, you will see a copayment (copay) assigned for the covered health service.

- If you use an in-network provider, you will pay lower copays and the provider will not charge you any additional fees.
- When medical services are received from a non-network provider, eligible expenses are an amount negotiated by UnitedHealthcare or contracted vendor, a specific amount required by law (when required by law) or an amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service.

## UnitedHealthcare® (UHC) Enhanced plan options

Please note: For the medical services shown in the table below and on the following pages, where coverage is expressed as a percentage, it is a percentage of the provider's contracted rate for in-network UHC Enhanced and UHC Standard services. When medical services are received from a non-network provider, eligible expenses are an amount negotiated by UHC, a specific amount required by law (when required by law) or an amount UHC has determined is typically accepted by a healthcare provider for the same or similar service.

	Surest Enhanced		UHC Enhanced	
	In-network	Out-of-network	In-network	Out-of-network
<b>Overall provisions</b>				
<b>Choice of doctors</b>	Select from within a network of medical providers	Select any medical provider	Select from within a network of medical providers	Select any medical provider
<b>Annual medical deductible</b>	\$0	\$0	Not applicable	<b>Individual:</b> \$1,000 <b>Two-person:</b> \$2,000 <b>Family:</b> \$3,000
<b>Coinsurance (Plan paid)</b>	100%	100%	Generally 85%, but varies by service; see below	Generally 60%, but varies by service; see below
<b>Medical annual out-of-pocket limit</b>	<b>Individual:</b> \$3,000 <b>Family:</b> \$6,000	<b>Individual:</b> \$6,000 <b>Family:</b> \$18,000	<b>Individual:</b> \$3,000 <b>Family:</b> \$6,000	<b>Individual:</b> \$5,000 (excludes deductible) <b>Family:</b> \$15,000 (excludes deductible)
<b>Lifetime maximum benefit</b>	Unlimited for essential benefits. Generally, the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care). For all other benefits: unlimited; some exclusions apply.			
<b>Annual maximum benefit</b>	Not applicable	Not applicable	Not applicable	Not applicable

	Surest Enhanced		UHC Enhanced	
	In-network	Out-of-network	In-network	Out-of-network
<b>Copays/coinsurance for covered services</b>				
<b>Acupuncture</b>	You pay \$30 copay/visit <i>Limited to 30 visits/ person/plan year</i>	You pay \$90 copay/visit <i>Limited to 30 visits/ person/plan year</i>	Plan pays 85%	Plan pays 60% after deductible is satisfied; limited to 30 visits/year
<b>Ambulance services (air and ground) — emergency</b>	You pay \$160 copay/transport	You pay \$160 copay/transport	Plan pays 85%	Plan pays 85%
<b>Ambulance services (air and ground) — non-emergency</b>	You pay \$160 copay/transport	You pay \$160 copay/transport	Plan pays 85%	Plan pays 85%
<b>Anesthesia</b>	You pay \$0 copay	You pay \$0 copay	Plan pays 85%	Plan pays 60% after deductible is satisfied
<b>Autism spectrum disorder services</b>	<b>Virtual:</b> You pay \$10 copay/visit <b>Outpatient (home/office):</b> You pay \$10 copay/visit <b>Outpatient (facility):</b> You pay \$70 copay/visit <b>Inpatient:</b> You pay \$1,600 copay/stay	<b>Virtual visit:</b> Not covered <b>Outpatient (home/office):</b> You pay \$100 copay/visit <b>Outpatient (facility):</b> You pay \$210 copay/visit <b>Inpatient:</b> You pay \$4,800 copay/stay	<b>Inpatient:</b> Plan pays 85% <b>Outpatient:</b> You pay \$30 copay/visit	<b>Inpatient:</b> Plan pays 60% after deductible is satisfied and you pay \$300 copay/admission <b>Outpatient:</b> Plan pays 60% after deductible is satisfied
<b>Birth control</b> (prescription birth control or medication only)	See “Coverage through the CVS Caremark prescription drug program” on page 14.			
<b>Birthing center</b>	You pay \$625 – \$1,375 copay/stay	You pay \$4,125 copay/stay	Plan pays 85%	Plan pays 60% after deductible is satisfied
<b>Blood and blood derivatives</b>	<b>Outpatient:</b> You pay \$75 – \$500 copay/visit <b>Inpatient:</b> You pay \$1,600 copay/visit	<b>Outpatient:</b> You pay \$1,500 copay/visit <b>Inpatient:</b> You pay \$4,800 copay/visit	Plan pays 85%	Plan pays 60% after deductible is satisfied
<b>Cardiac rehabilitation</b> (phase three maintenance not covered)	You pay \$30 copay/visit	You pay \$90 copay/visit	Plan pays 85%	Plan pays 60% after deductible is satisfied
<b>Chemotherapy</b>	You pay \$10 – \$500 copay/visit	You pay up to \$1,500 copay/visit	Plan pays 85%	Plan pays 60% after deductible is satisfied
<b>Chiropractic</b>	You pay \$10 copay/visit <i>Limited to 30 visits/ person/plan year</i>	You pay \$30 copay/visit <i>Limited to 30 visits/ person/plan year</i>	You pay \$40 copay/visit; limited to 30 visits/year (in- and out-of-network combined)	Plan pays 60% after deductible is satisfied; limited to 30 visits/year (in- and out-of-network combined)
<b>Colonoscopy — preventive and diagnostic</b>	<b>Preventive and diagnostic:</b> You pay \$0 copay/visit	<b>Preventive:</b> You pay \$100 copay/visit <b>Diagnostic:</b> You pay \$3,000 copay/visit	Plan pays 100%	Plan pays 60% after deductible is satisfied

	Surest Enhanced		UHC Enhanced	
	In-network	Out-of-network	In-network	Out-of-network
<b>Dental services — accident only</b>	<b>Office:</b> You pay \$10 – \$65 copay/visit <b>Outpatient:</b> You pay \$75 – \$500 copay/visit <b>Inpatient:</b> You pay \$1,600 copay/visit	<b>Office:</b> You pay \$195 copay/visit <b>Outpatient:</b> You pay \$2,850 copay/visit <b>Inpatient:</b> You pay \$4,800 copay/visit	Plan pays 100% after you pay \$30 PCP/ \$40 specialist copay/visit	Plan pays 60% after deductible is satisfied
<b>Diabetes self-management items</b>	You pay \$0 – \$500 copay for diabetic supplies	You pay \$20 – \$1,000 copay for diabetic supplies	<b>Equipment:</b> Plan pays 85% <b>Supplies:</b> Provided under the prescription drug program	<b>Equipment:</b> Plan pays 60% after deductible is satisfied <b>Supplies:</b> Provided under the prescription drug program
<b>Durable medical equipment</b>	You pay \$0 – \$500 copay	You pay up to \$1,000 copay	Plan pays 85%	Plan pays 60% after deductible is satisfied
<b>Emergency room — emergency use</b>	You pay \$300 copay/visit (waived if admitted within 24 hours)	You pay \$300 copay/visit (waived if admitted within 24 hours)	You pay \$150 copay (waived if admitted)	You pay \$150 copay (waived if admitted)
<b>Emergency room — nonemergency use</b>	You pay \$300 copay/visit	You pay \$300 copay/visit	You pay \$150 copay (waived if admitted)	You pay \$150 copay (waived if admitted)
<b>Fertility services</b>	Plan pays up to a maximum benefit of \$15,000/covered member/lifetime; for a list of covered services and copays, see the Summary Plan Description (SPD) at <a href="http://www.benefitanswersplus.com/active_m/spd.html">www.benefitanswersplus.com/active_m/spd.html</a>	Not covered	See the SPD	See the SPD
<b>Habilitative and rehabilitation services</b> (outpatient physical, occupational, speech)	You pay \$5 – \$60 copay/visit <i>Each type of therapy is limited to 100 visits/person/plan year; not combined with other therapies; in- and out-of-network combined</i>	You pay \$135 – \$180 copay/visit <i>Each type of therapy is limited to 100 visits/person/plan year; not combined with other therapies; in- and out-of-network combined</i>	<b>Physical, occupational, speech and pulmonary rehabilitation:</b> You pay \$40 copay/visit	Plan pays 60% after deductible is satisfied; speech therapy limited to 100 visits/year for developmental delays and 30 visits/year otherwise
<b>Hearing aids</b>	You pay \$0 copay; plan pays a maximum of \$5,000 every 36 months for in- and out-of-network providers combined		\$2,500 allowance every 36 months (in- and out-of-network combined)	\$2,500 allowance every 36 months (in- and out-of-network combined)
<b>Home healthcare</b>	You pay \$30 copay/visit <i>100-visit limit/person/plan year; in- and out-of-network combined</i>	You pay \$90 copay/visit <i>100-visit limit/person/plan year; in- and out-of-network combined</i>	Plan pays 85%	Plan pays 60% after deductible is satisfied; limited to 100 visits/year



	Surest Enhanced		UHC Enhanced	
	In-network	Out-of-network	In-network	Out-of-network
<b>Hospice care</b>	<b>Home:</b> You pay \$30 copay/visit <b>Inpatient:</b> You pay \$1,600 copay/stay	<b>Home:</b> You pay \$90 copay/visit <b>Inpatient:</b> You pay \$4,800 copay/stay	Plan pays 85%	Plan pays 60% after deductible is satisfied
<b>Inpatient hospitalization</b>	You pay \$150 – \$2,500 copay/stay	You pay \$3,000 – \$5,000 copay/stay	Plan pays 85%	Plan pays 60% after deductible is satisfied and you pay \$300 copay/admission
<b>Maternity</b> (office visits [pre/postnatal], in-hospital delivery services)	<b>Office visits (pre/postnatal):</b> You pay \$0 copay/visit <b>In-hospital delivery services:</b> You pay \$625 – \$1,375 copay/stay	<b>Office visits (pre/postnatal):</b> You pay \$100 copay/visit <b>In-hospital delivery services:</b> You pay \$4,125 copay/stay	<b>Office visits:</b> Plan pays 85% after you pay first office copay <b>In-hospital delivery services:</b> Plan pays 85%	<b>Office visits:</b> Plan pays 60% after deductible is satisfied <b>In-hospital delivery services:</b> Plan pays 60% after deductible is satisfied and you pay \$300 copay/admission
<b>Medical infusions</b>	You pay \$10 – \$2,450 copay/visit	You pay up to \$5,000	See the SPD	See the SPD
<b>Mental health and chemical dependency</b>	<b>Virtual:</b> You pay \$10 copay/visit <b>Outpatient (home/office):</b> You pay \$10 copay/visit <b>Outpatient (facility):</b> You pay \$70 copay/visit <b>Inpatient:</b> You pay \$1,600 copay/stay	<b>Virtual visit:</b> Not covered <b>Outpatient (home/office):</b> You pay \$20 copay/visit <b>Outpatient (facility):</b> You pay \$210 copay/visit <b>Inpatient:</b> You pay \$4,800 copay/stay	<b>Inpatient:</b> Plan pays 85% <b>Outpatient:</b> You pay \$30 copay/visit	<b>Inpatient:</b> Plan pays 60% after deductible is satisfied and you pay \$300 copay/admission <b>Outpatient:</b> Plan pays 60% after deductible is satisfied
<b>Nutritional counseling</b>	See the SPD	See the SPD	You pay \$40 copay/visit	Not covered
<b>Outpatient lab/X-ray/ultrasound/complex imaging</b>	<b>Routine diagnostic test:</b> You pay \$0 copay <b>Non-routine diagnostic test:</b> You pay \$20 – \$600 copay/visit <b>Complex imaging:</b> You pay \$75 – \$500 copay/visit	<b>Routine diagnostic test:</b> You pay \$0 copay <b>Non-routine diagnostic test:</b> You pay \$135 – \$1,800 copay/visit <b>Complex imaging:</b> You pay \$1,500 copay/visit	Plan pays 100% for minor services; 85% for major services	Plan pays 60% after deductible is satisfied
<b>Physician hospital visits and consultations</b>	You pay \$0 copay	You pay \$0 copay	Plan pays 85%	Plan pays 60% after deductible is satisfied

	Surest Enhanced		UHC Enhanced	
	In-network	Out-of-network	In-network	Out-of-network
<b>Physician visits</b> (primary care physician [PCP] office visits, specialist office visits, urgent care center visits and virtual visits) (non-preventive)	<b>PCP and specialist:</b> You pay \$10 – \$65 copay/visit <b>Urgent care center:</b> You pay \$65 copay/visit <b>Virtual visit (urgent and acute care and primary care):</b> You pay \$0 copay/visit <b>Virtual visit (specialty):</b> You pay \$0 – \$65 copay/visit	<b>PCP, specialist and urgent care center:</b> You pay \$195 copay/visit <b>Virtual visit:</b> Not covered	<b>Virtual visit:</b> You pay \$10 copay/visit <b>PCP:</b> You pay \$30 copay/visit <b>Specialist:</b> You pay \$40 copay/visit <b>Urgent care center:</b> You pay \$75 copay/visit	<b>Virtual visit:</b> Not covered <b>PCP, specialist and urgent care center:</b> Plan pays 60% after deductible is satisfied
<b>Podiatrist</b>	<b>Office:</b> You pay \$10 – \$65 copay/visit	<b>Office:</b> You pay \$195 copay/visit	See the SPD	See the SPD
<b>Private duty nursing</b>	You pay \$30 copay/visit	You pay \$90 copay/visit	Plan pays 85%	Plan pays 60% after deductible is satisfied; limited to 100 shifts/year
<b>Prosthetic devices</b>	You pay \$0 – \$500 copay	You pay up to \$1,000 copay	Plan pays 85%	Plan pays 60% after deductible is satisfied
<b>Radiation therapy</b>	You pay \$30 – \$1,400 copay	You pay \$135 – \$4,200 copay	Plan pays 85%	Plan pays 60% after deductible is satisfied
<b>Second surgical opinion</b>	You pay \$0 through 2nd.MD	Not covered	You pay \$40 copay/visit	Plan pays 60% after deductible is satisfied
<b>Skilled nursing facility</b>	You pay \$1,600 copay/stay <i>100-day limit/person/plan year; in- and out-of-network combined</i>	You pay \$4,800 copay/stay <i>100-day limit/person/plan year; in- and out-of-network combined</i>	Plan pays 85%	Plan pays 60% after deductible is satisfied; limited to 60 days/year
<b>Smoking deterrents</b> (prescription only)	See "Coverage through the CVS Caremark prescription drug program" on page 14.			
<b>Surgery — in-office or outpatient</b>	You pay \$25 – \$2,500 copay/visit	You pay \$120 – \$5,000 copay/visit	Plan pays 85%	Plan pays 60% after deductible is satisfied
<b>Surgery — inpatient</b>	You pay \$150 – \$2,500 copay/visit	You pay \$3,000 – \$5,000 copay/visit	Plan pays 85%	Plan pays 60% after deductible is satisfied
<b>Wigs</b>	You pay \$0 – \$500 copay <i>Limited to one wig per plan year</i>	You pay \$20 – \$1,000 copay <i>Limited to one wig per plan year</i>	Plan pays up to \$300/year	

	Surest Enhanced		UHC Enhanced	
	In-network	Out-of-network	In-network	Out-of-network
<b>Preventive care</b>				
<b>Routine physical exams</b>	You pay \$0 copay/visit	You pay \$100 copay/visit	Plan pays 100%	Plan pays 60% after deductible is satisfied
<b>Well-child care</b> (including immunizations)	You pay \$0 copay/visit	You pay \$100 copay/visit	Plan pays 100%	Plan pays 60% after deductible is satisfied
<b>Well-woman care</b> (ob-gyn exam)	You pay \$0 copay/visit	You pay \$100 copay/visit	Plan pays 100%	Plan pays 60% after deductible is satisfied
<b>Mammogram screening</b>	You pay \$0 copay/visit	You pay \$100 /visit	Plan pays 100%	Plan pays 60% after deductible is satisfied
<b>Pap smear</b> (in doctor's office)	You pay \$0 copay/visit	You pay \$100 copay/visit	Plan pays 100%	Plan pays 60% after deductible is satisfied
<b>Digital rectal exam and blood test for PSA</b> (in doctor's office — prostate cancer screening for men age 50 and older)	You pay \$0 copay/visit	You pay \$100 copay/visit	Plan pays 100%	Plan pays 60% after deductible is satisfied
<b>Newborn in-hospital care</b>	You pay \$0 copay/visit	You pay \$100 copay/visit	Plan pays 100%	Plan pays 60% after deductible is satisfied
<b>Other important information about your medical coverage</b>				
<b>Are you responsible for charges in excess of the allowable amount?</b>	Not applicable	Not applicable	No	Yes
<b>Who is responsible for prior authorization?</b>	Your provider	You	Your provider; check with your provider to ensure prior authorization is obtained	You
<b>What is the penalty for failure to obtain prior authorization?</b>	Your provider will be responsible for 100% of the billed amount	You will be responsible for 100% of the billed amount	No benefits paid by plan	Up to \$400 maximum reduction in benefits/occurrence
<b>Do you have to file claim forms?</b>	No	Yes	No	Yes
<b>Are Centers of Excellence available?</b>	Transplant Resource Services	Not covered	Yes	

# Medical

## Surest Standard plan options

Please note: For the Surest medical services shown in the table below and on the following pages, you will see a copayment (copay) assigned for the covered health service.

- If you use an in-network provider, you will pay lower copays and the provider will not charge you any additional fees.
- When medical services are received from a non-network provider, eligible expenses are an amount negotiated by UnitedHealthcare or contracted vendor, a specific amount required by law (when required by law) or an amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service.

## UnitedHealthcare® (UHC) Standard plan options

Please note: For the medical services shown in the table below and on the following pages, where coverage is expressed as a percentage, it is a percentage of the provider's contracted rate for in-network UHC Enhanced and UHC Standard services. When medical services are received from a non-network provider, eligible expenses are an amount negotiated by UHC, a specific amount required by law (when required by law) or an amount UHC has determined is typically accepted by a healthcare provider for the same or similar service.

	Surest Standard		UHC Standard	
	In-network	Out-of-network	In-network	Out-of-network
Overall provisions				
Choice of doctors	Select from within a network of medical providers	Select any medical provider	Select from within a network of medical providers	Select any medical provider
Annual medical deductible	\$0	\$0	Not applicable	<b>Individual:</b> \$1,500 <b>Two-person:</b> \$3,000 <b>Family:</b> \$4,500
Coinsurance (Plan paid)	100%	100%	Generally 75%, but varies by service; see below	Generally 50%, but varies by service; see below
Medical annual out-of-pocket limit	<b>Individual:</b> \$4,000 <b>Family:</b> \$8,000	<b>Individual:</b> \$10,500 <b>Family:</b> \$31,500	<b>Individual:</b> \$4,000 <b>Family:</b> \$8,000	<b>Individual:</b> \$9,000 (excludes deductible) <b>Family:</b> \$27,000 (excludes deductible)
Lifetime maximum benefit	Unlimited for essential benefits. Generally, the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care). For all other benefits: unlimited; some exclusions apply.			
Annual maximum benefit	Not applicable	Not applicable	Not applicable	Not applicable



	Surest Standard		UHC Standard	
	In-network	Out-of-network	In-network	Out-of-network
Copays/coinsurance for covered services				
<b>Acupuncture</b>	You pay \$60 copay/visit <i>Limited to 30 visits/ person/plan year</i>	You pay \$180 copay/visit <i>Limited to 30 visits/ person/plan year</i>	Plan pays 75%	Plan pays 50% after deductible is satisfied; limited to 30 visits/year
<b>Ambulance services (air and ground) — emergency</b>	You pay \$350 copay/transport	You pay \$350 copay/transport	Plan pays 75%	Plan pays 75%
<b>Ambulance services (air and ground) — non-emergency</b>	You pay \$350 copay/transport	You pay \$350 copay/transport	Plan pays 75%	Plan pays 75%
<b>Anesthesia</b>	You pay \$0 copay	You pay \$0 copay	Plan pays 75%	Plan pays 50% after deductible is satisfied
<b>Autism spectrum disorder services</b>	<b>Virtual:</b> You pay \$25 copay/visit <b>Outpatient (home/office):</b> You pay \$25 copay/visit <b>Outpatient (facility):</b> You pay \$140 copay/visit <b>Inpatient:</b> You pay \$2,750 copay/stay	<b>Virtual visit:</b> Not covered <b>Outpatient (home/office):</b> You pay \$190 copay/visit <b>Outpatient (facility):</b> You pay \$420 copay/visit <b>Inpatient:</b> You pay \$8,250 copay/stay	<b>Inpatient:</b> Plan pays 75% after you pay \$500 copay/admission <b>Outpatient:</b> You pay \$35 copay/visit	<b>Inpatient:</b> Plan pays 50% after deductible is satisfied and you pay \$700 copay/admission <b>Outpatient:</b> Plan pays 50% after deductible is satisfied
<b>Birth control</b> (prescription birth control or medication only)	See “Coverage through the CVS Caremark prescription drug program” on page 14.			
<b>Birth center</b>	You pay \$1,300 – \$2,350 copay/stay	You pay \$7,050 copay/stay	Plan pays 75% after you pay \$300 copay/admission	Plan pays 50% after deductible is satisfied
<b>Blood and blood derivatives</b>	<b>Outpatient:</b> You pay \$150 – \$950 copay/visit <b>Inpatient:</b> You pay \$2,750 copay/visit	<b>Outpatient:</b> You pay \$2,850 copay/visit <b>Inpatient:</b> You pay \$8,250 copay/visit	Plan pays 75%	Plan pays 50% after deductible is satisfied
<b>Cardiac rehabilitation</b> (phase three maintenance not covered)	You pay \$60 copay/visit	You pay \$180 copay/visit	Plan pays 75%	Plan pays 50% after deductible is satisfied
<b>Chemotherapy</b>	You pay \$50 – \$600 copay/visit	You pay up to \$1,800 copay/visit	Plan pays 75%	Plan pays 50% after deductible is satisfied
<b>Chiropractic</b>	You pay \$20 copay/visit <i>Limited to 30 visits/ person/plan year</i>	You pay \$60 copay/visit <i>Limited to 30 visits/ person/plan year</i>	You pay \$60 copay/visit; limited to 30 visits/year (in- and out-of-network combined)	Plan pays 50% after deductible is satisfied; limited to 30 visits/year (in- and out-of-network combined)
<b>Colonoscopy — preventive and diagnostic</b>	<b>Preventive and diagnostic:</b> You pay \$0 copay/visit	<b>Preventive:</b> You pay \$190 copay/visit <b>Diagnostic:</b> You pay \$5,550 copay/visit	Plan pays 100%	Plan pays 50% after deductible is satisfied

	Surest Standard		UHC Standard	
	In-network	Out-of-network	In-network	Out-of-network
<b>Dental services — accident only</b>	<b>Office:</b> You pay \$25 – \$125 copay/visit <b>Outpatient:</b> You pay \$150 – \$950 copay/visit <b>Inpatient:</b> You pay \$2,750 copay/visit	<b>Office:</b> You pay \$375 copay/visit <b>Outpatient:</b> You pay \$1,500 copay/visit <b>Inpatient:</b> You pay \$8,250 copay/visit	Plan pays 100% after you pay \$35 PCP/ \$60 specialist copay/visit	Plan pays 50% after deductible is satisfied
<b>Diabetes self-management items</b>	You pay \$0 – \$1,000 copay for diabetic supplies	You pay \$20 – \$2,000 copay for diabetic supplies	<b>Equipment:</b> Plan pays 75% <b>Supplies:</b> Provided under the prescription drug program	<b>Equipment:</b> Plan pays 50% after deductible is satisfied <b>Supplies:</b> Provided under the prescription drug program
<b>Durable medical equipment</b>	You pay \$0 – \$1,000 copay	You pay up to \$2,000 copay	Plan pays 75%	Plan pays 50% after deductible is satisfied
<b>Emergency room — emergency use</b>	You pay \$500 copay/visit (waived if admitted within 24 hours)	You pay \$500 copay/visit (waived if admitted within 24 hours)	You pay \$200 copay (waived if admitted)	You pay \$200 copay (waived if admitted)
<b>Emergency room — nonemergency use</b>	You pay \$500 copay/visit	You pay \$500 copay/visit	You pay \$200 copay (waived if admitted)	You pay \$200 copay (waived if admitted)
<b>Fertility services</b>	Plan pays up to a maximum benefit of \$15,000/covered member/lifetime; for a list of covered services and copays, see the Summary Plan Description (SPD) at <a href="http://www.benefitanswersplus.com/active_m/spd.html">www.benefitanswersplus.com/active_m/spd.html</a>	Not covered	See the SPD	See the SPD
<b>Habilitative and rehabilitation services</b> (outpatient physical, occupational, speech)	You pay \$15 – \$115 copay/visit <i>Each type of therapy is limited to 100 visits/person/plan year; not combined with other therapies; in- and out-of-network combined</i>	You pay \$255 – \$345 copay/visit <i>Each type of therapy is limited to 100 visits/person/plan year; not combined with other therapies; in- and out-of-network combined</i>	<b>Physical, occupational, speech and pulmonary rehabilitation:</b> You pay \$60 copay/visit	Plan pays 50% after deductible is satisfied; speech therapy limited to 100 visits/year for developmental delays and 30 visits/year otherwise
<b>Hearing aids</b>	You pay \$0 copay; plan pays a maximum of \$5,000 every 36 months for in- and out-of-network providers combined		\$2,500 allowance every 36 months (in- and out-of-network combined)	\$2,500 allowance every 36 months (in- and out-of-network combined)
<b>Home healthcare</b>	You pay \$60 copay/visit <i>100-visit limit/person/plan year; in- and out-of-network combined</i>	You pay \$180 copay/visit <i>100-visit limit/person/plan year; in- and out-of-network combined</i>	Plan pays 75%	Plan pays 50% after deductible is satisfied; limited to 100 visits/year

	Surest Standard		UHC Standard	
	In-network	Out-of-network	In-network	Out-of-network
<b>Hospice care</b>	<b>Home:</b> You pay \$60 copay/visit <b>Inpatient:</b> You pay \$2,750 copay/stay	<b>Home:</b> You pay \$180 copay/visit <b>Inpatient:</b> You pay \$8,250 copay/stay	Plan pays 75%	Plan pays 50% after deductible is satisfied
<b>Inpatient hospitalization</b>	You pay \$400 – \$3,500 copay/stay	You pay \$5,550 – \$9,500 copay/stay	Plan pays 75% after you pay \$500 copay/admission	Plan pays 50% after deductible is satisfied and you pay \$700 copay/admission
<b>Maternity</b> (office visits [pre/postnatal], in-hospital delivery services)	<b>Office visits (pre/postnatal):</b> You pay \$0 copay/visit <b>In-hospital delivery services:</b> You pay \$1,300 – \$2,350 copay/stay	<b>Office visits (pre/postnatal):</b> You pay \$190 copay/visit <b>In-hospital delivery services:</b> You pay \$7,050 copay/stay	<b>Office visits:</b> Plan pays 75% after you pay first office copay <b>In-hospital delivery services:</b> Plan pays 75% after you pay \$500 copay/admission	<b>Office visits:</b> Plan pays 50% after deductible is satisfied <b>In-hospital delivery services:</b> Plan pays 50% after deductible is satisfied and you pay \$700 copay/admission
<b>Medical infusions</b>	You pay \$40 – \$3,500 copay/visit	You pay up to \$9,000	See the SPD	See the SPD
<b>Mental health and chemical dependency</b>	<b>Virtual visit:</b> You pay \$25 copay/visit <b>Outpatient (home/office):</b> You pay \$25 copay/visit <b>Outpatient (facility):</b> You pay \$140 copay/visit <b>Inpatient:</b> You pay \$2,750 copay/stay	<b>Virtual visit:</b> Not covered <b>Outpatient (home/office):</b> You pay \$50 copay/visit <b>Outpatient (facility):</b> You pay \$420 copay/visit <b>Inpatient:</b> You pay \$8,250 copay/stay	<b>Inpatient:</b> Plan pays 75% after you pay \$500 copay/admission <b>Outpatient:</b> You pay \$35 copay/visit	<b>Inpatient:</b> Plan pays 50% after deductible is satisfied and you pay \$700 copay/admission <b>Outpatient:</b> Plan pays 50% after deductible is satisfied
<b>Nutritional counseling</b>	See the SPD	See the SPD	You pay \$60 copay/visit	Not covered
<b>Outpatient lab/X-ray/ultrasound/complex imaging</b>	<b>Routine diagnostic test:</b> You pay \$0 copay <b>Non-routine diagnostic test:</b> You pay \$40 – \$1,150 copay/visit <b>Complex imaging:</b> You pay \$180 – \$950 copay/visit	<b>Routine diagnostic test:</b> You pay \$0 copay <b>Non-routine diagnostic test:</b> You pay \$270 – \$3,450 copay/visit <b>Complex imaging:</b> You pay \$2,850 copay/visit	Plan pays 100% for minor services; 75% for major services	Plan pays 50% after deductible is satisfied
<b>Physician hospital visits and consultations</b>	You pay \$0 copay	You pay \$0 copay	Plan pays 75%	Plan pays 50% after deductible is satisfied

	Surest Standard		UHC Standard	
	In-network	Out-of-network	In-network	Out-of-network
<b>Physician visits</b> (primary care physician [PCP] office visits, specialist office visits, urgent care center visits and virtual visits) (non-preventive)	<b>PCP and specialist:</b> You pay \$25 – \$125 copay/visit <b>Urgent care center:</b> You pay \$100 copay/visit <b>Virtual visit (urgent and acute care and primary care):</b> You pay \$0 copay/visit <b>Virtual visit (specialty):</b> You pay \$0 – \$125 copay/visit	<b>PCP and specialist:</b> You pay \$375 copay/visit <b>Urgent care center:</b> You pay \$300 copay/visit <b>Virtual visit:</b> Not covered	<b>Virtual visit:</b> You pay \$20 copay/visit <b>PCP:</b> You pay \$35 copay/visit <b>Specialist:</b> You pay \$60 copay/visit <b>Urgent care center:</b> You pay \$100 copay/visit	<b>Virtual visit:</b> Not covered <b>PCP, specialist and urgent care center:</b> Plan pays 50% after deductible is satisfied
<b>Podiatrist</b>	<b>Office:</b> You pay \$25 – \$125 copay/visit	<b>Office:</b> You pay \$375 copay/visit	See the SPD	See the SPD
<b>Private duty nursing</b>	You pay \$60 copay/visit	You pay \$180 copay/visit	Plan pays 75%	Plan pays 50% after deductible is satisfied; limited to 100 shifts/year
<b>Prosthetic devices</b>	You pay \$0 – \$1,000 copay	You pay up to \$2,000 copay	Plan pays 75%	Plan pays 50% after deductible is satisfied
<b>Radiation therapy</b>	You pay \$60 – \$2,400 copay	You pay \$750 – \$7,200 copay	Plan pays 75%	Plan pays 50% after deductible is satisfied
<b>Second surgical opinion</b>	You pay \$0 through 2nd.MD	Not covered	You pay \$60 copay/visit	Plan pays 50% after deductible is satisfied
<b>Skilled nursing facility</b>	You pay \$2,750 copay/stay <i>100-day limit/person/plan year; in- and out-of-network combined</i>	You pay \$8,250 copay/stay <i>100-day limit/person/plan year; in- and out-of-network combined</i>	Plan pays 75%	Plan pays 50% after deductible is satisfied; limited to 60 days/year
<b>Smoking deterrents</b> (prescription only)	See “Coverage through the CVS Caremark prescription drug program” on page 14.			
<b>Surgery — in-office or outpatient</b>	You pay \$50 – \$3,500 copay/visit	You pay \$270 – \$9,500 copay/visit	<b>In-office:</b> Plan pays 75% after you pay \$250 copay <b>Outpatient:</b> Plan pays 75% after you pay \$300 copay/procedure	Plan pays 50% after deductible is satisfied
<b>Surgery — inpatient</b>	You pay \$400 – \$3,500 copay/visit	You pay \$5,550 – \$9,500 copay/visit	Plan pays 75%	Plan pays 50% after deductible is satisfied
<b>Wigs</b>	You pay \$0 – \$1,000 copay <i>Limited to one wig per plan year</i>	You pay \$20 – \$2,000 copay <i>Limited to one wig per plan year</i>	Plan pays up to \$300/year	

	Surest Standard		UHC Standard	
	In-network	Out-of-network	In-network	Out-of-network
<b>Preventive care</b>				
<b>Routine physical exams</b>	You pay \$0 copay/visit	You pay \$190 copay/visit	Plan pays 100%	Plan pays 50% after deductible is satisfied
<b>Well-child care</b> (including immunizations)	You pay \$0 copay/visit	You pay \$190 copay/visit	Plan pays 100%	Plan pays 50% after deductible is satisfied
<b>Well-woman care</b> (ob-gyn exam)	You pay \$0 copay/visit	You pay \$190 copay/visit	Plan pays 100%	Plan pays 50% after deductible is satisfied
<b>Mammogram screening</b>	You pay \$0 copay/visit	You pay \$190 copay/visit	Plan pays 100%	Plan pays 50% after deductible is satisfied
<b>Pap smear</b> (in doctor's office)	You pay \$0 copay/visit	You pay \$190 copay/visit	Plan pays 100%	Plan pays 50% after deductible is satisfied
<b>Digital rectal exam and blood test for PSA</b> (in doctor's office — prostate cancer screening for men age 50 and older)	You pay \$0 copay/visit	You pay \$190 copay/visit	Plan pays 100%	Plan pays 50% after deductible is satisfied
<b>Newborn in-hospital care</b>	You pay \$0 copay/visit	You pay \$190 copay/visit	Plan pays 100%	Plan pays 50% after deductible is satisfied
<b>Other important information about your medical coverage</b>				
<b>Are you responsible for charges in excess of the allowable amount?</b>	Not applicable	Not applicable	No	Yes
<b>Who is responsible for prior authorization?</b>	Your provider	You	Your provider; check with your provider to ensure prior authorization is obtained	You
<b>What is the penalty for failure to obtain prior authorization?</b>	Your provider will be responsible for 100% of the billed amount	You will be responsible for 100% of the billed amount	No benefits paid by plan	Up to \$400 maximum reduction in benefits/occurrence
<b>Do you have to file claim forms?</b>	No	Yes	No	Yes
<b>Are Centers of Excellence available?</b>	Transplant Resource Services	Not covered	Yes	



# Prescription drug coverage

	Surest Enhanced and UHC Enhanced		Surest Standard and UHC Standard	
	In-network	Out-of-network	In-network	Out-of-network
Coverage through the CVS Caremark prescription drug program <sup>1,2</sup>				
Prescription drug annual out-of-pocket limit	Individual: \$3,500 Family: \$7,000	Not applicable	Individual: \$4,000 Family: \$8,000	Not applicable
Retail <sup>3</sup> (up to a 30-day supply using an in-network pharmacy)	Generic: \$20 copay Preferred brand: \$70 copay Nonpreferred brand: \$100 copay	Plan pays 60% coinsurance after you pay separate deductible Individual: \$150 Two-person: \$300 Family: \$450	You pay \$20 copay for generic drugs and 50% coinsurance for brand-name drugs, with an out-of-pocket minimum of \$20 and maximum of \$120/prescription	Plan pays 50% coinsurance after you pay separate deductible: Individual: \$200 Two-person: \$400 Family: \$600
Mail order (up to a 90-day supply)	Generic: \$50 copay Preferred brand: \$175 copay Nonpreferred brand: \$250 copay	Not applicable	You pay \$50 copay for generic drugs and 50% coinsurance for brand-name drugs, with an out-of-pocket minimum of \$50 and maximum of \$300/prescription	Not applicable
Member pays the difference	You will pay the generic copay, plus the difference in cost between the brand-name and generic drug, if you purchase a brand-name drug when a generic equivalent is available.			
Other important information about your medical and prescription drug coverage				
\$0 out-of-pocket cost for certain preventive medications	Certain preventive medications, including some over-the-counter (OTC) medications, are covered 100% without imposing a copay, coinsurance or deductible as long as they are presented with a prescription from a licensed healthcare provider. The list of eligible medications is subject to change as Affordable Care Act guidelines are updated or modified.			

<sup>1</sup> The deductibles and out-of-pocket maximums for the prescription drug program are separate from the deductibles and/or out-of-pocket maximums for Surest and UHC medical coverage. "Member pays the difference" program charges do not count toward prescription drug annual out-of-pocket maximums.

<sup>2</sup> Where prescription drug coverage is expressed as a percentage, it is a percentage of the plan's cost for the drug.

<sup>3</sup> Prescription drug copays will double after the third time you receive a 30-day supply of a maintenance medication at a retail pharmacy; for cost savings, fill up to a 90-day supply through mail order or pick up at a CVS retail pharmacy or at any Costco Pharmacy. Note the following state exceptions to the doubling of copays: **FLORIDA:** Participants residing in Florida can also obtain 90-day supplies of medications taken on an ongoing basis at any in-network retail pharmacy that fills 90-day supplies. **MINNESOTA:** Participants residing in MN also have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find an in-network participating pharmacy. **OKLAHOMA:** Participants residing in or filling their prescriptions in Oklahoma can also obtain 90-day supplies of medications taken on an ongoing basis at any in-network retail pharmacy that fills 90-day supplies. **TENNESSEE:** Participants residing in Tennessee also have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find an in-network participating pharmacy. **WEST VIRGINIA:** Participants residing in West Virginia will have access to an expanded list of pharmacies from which to obtain 90-day supplies of medications they take on an ongoing basis. Sign into Caremark.com to find a participating pharmacy.

**Note:** Your CVS Caremark prescription drug coverage includes the PrudentRx Copay Program, a cost-saving program for certain specialty medications. For information about PrudentRx, see the *Nokia Medical Expense Plan for Active Employees Plan Document and Summary Plan Description (SPD) — Surest Enhanced and Standard Options* and the *Nokia Medical Expense Plan for Active Employees Plan Document and SPD — UHC Enhanced and Standard Options* at [www.benefitanswersplus.com/active\\_m/spd.html](http://www.benefitanswersplus.com/active_m/spd.html).