EMPLOYER & INDIVIDUAL HEALTH INSURANCE

2015-2016

UnitedHealthcare®

YOUR BENEFITS

Benefit Summary

Texas - Insurance Choice Plus
Premier - 20/250/100% Plan 2TT

We know that when people know more about their health and health care, they can make better informed health care decisions. We want to help you understand more about your health care and the resources that are available to you.

- **myuhc.com®** – Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	$250 per year	$5,000 per year
Family Deductible	$500 per year	$10,000 per year

> Copayments do not accumulate towards the Deductible.

> All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.

Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	$1,750 per year	$10,000 per year
Family Out-of-Pocket Maximum	$3,500 per year	$20,000 per year

> All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.

> Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents shall prevail. It is recommended that you review these documents for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

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UnitedHealthcare Insurance Company

Prescription Drug Benefits

Prescription drug benefits are shown under separate cover.

Additional Benefit Information

> Refer to your Certificate of Coverage or Summary of Benefits and Coverage to determine if the Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a Policy or Calendar year basis.

> Refer to your Certificate of Coverage and your Riders for the definition of Eligible Expenses and information on how Benefits are paid.

> When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

MOST COMMONLY USED BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit No deductible is applicable to necessary diagnostic follow-up care relating to the screening test for hearing loss of newborn Dependents, from birth through 24 months.	Covered persons less than age 19: 100% after you pay a $0 Copayment per visit. All other Covered Persons: Designated Network: 100% after you pay a $20 Copayment per visit. Network: 100% after you pay a $20 Copayment per visit.	70% after Deductible has been met.
Specialist Physician Office Visit	Designated Network: 100% after you pay a $20 Copayment per visit. Network: 100% after you pay a $40 Copayment per visit.	70% after Deductible has been met. *Prior Authorization is required for Genetic Testing BRCA.*

> In addition to the office visit Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

Preventive Care Services

Covered Health Services include but are not limited to:

Primary Physician Office Visit	100%, Copayments and Deductibles do not apply.	70% after Deductible has been met.
Specialist Physician Office Visit	100%, Copayments and Deductibles do not apply.	
Lab, X-Ray or other preventive tests	100%, Copayments and Deductibles do not apply.	

The health care reform law provides for coverage of certain preventive services, based on your age, gender and other health factors, with no cost-sharing. The preventive care services covered under this section are those preventive services specified in the health care reform law. UnitedHealthcare also covers other routine services as described in other areas of this summary, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Types of Coverage	Network Benefits	Non-Network Benefits
gent Care Center Services		
	100% after you pay a $75 Copayment per visit.	70% after Deductible has been met.
> In addition to the Copayment stated in this section, the Copayment/Coinsurance and any deductible applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.		
Emergency Health Services - Outpatient		
	100% after you pay a $300 Copayment per visit.	100% after you pay a $300 Copayment per visit. *Notification is required if confined in a non-Network Hospital.*
Hospital - Inpatient Stay		
	100% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance	100% after Deductible has been met.	100% after Network Deductible has been met.
Air Ambulance	100% after Deductible has been met.	100% after Network Deductible has been met.
	Prior Authorization is required for non-Emergency Ambulance.	*Prior Authorization is required for non-Emergency Ambulance.*
Congenital Heart Disease (CHD) Surgeries		
	100% after Deductible has been met.	70% after Deductible has been met.
		Prior Authorization is required.
Dental Services - Accident Only		
	100% after Deductible has been met.	100% after Network Deductible has been met.
	Prior Authorization is required.	*Prior Authorization is required.*
Diabetes Services		
Diabetes Self Management and Training Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Diabetes Self Management Items Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with diabetes.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Rider.	
		Prior Authorization is required for diabetes equipment in excess of $1,000.
Durable Medical Equipment		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	100% after Deductible has been met.	70% after Deductible has been met.
		Prior Authorization is required for Durable Medical Equipment in excess of $1,000.
Habilitative Services		
	Benefits for Habilitative Services are provided under and as part of Rehabilitation Services – Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated below in this benefit summary.	
Hearing Aids		
Benefits are limited as follows: A single purchase (including repair/ replacement) per hearing impaired ear every three years.	100% after Deductible has been met.	70% after Deductible has been met.
Home Health Care		
Benefits are limited as follows: 60 visits per year	100% after Deductible has been met.	70% after Deductible has been met.
		Prior Authorization is required.

Types of Coverage	Network Benefits	Non-Network Benefits
spice Care		
	100% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required for Inpatient Stay.*
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.		
Lab Testing - Outpatient	100% Deductible does not apply.	70% after Deductible has been met.
X-Ray and Other Diagnostic Testing - Outpatient	100% Deductible does not apply.	70% after Deductible has been met. *Prior Authorization is required for sleep studies.*
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	100% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*
Ostomy Supplies		
Benefits are limited as follows: $2,500 per year	100% after Deductible has been met.	70% after Deductible has been met.
Pharmaceutical Products - Outpatient		
his includes medications administered in outpatient setting, in the Physician's Office, or in a Covered Person's home.	100% after Deductible has been met.	70% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	Designated Network: 100% after Deductible has been met for Primary Care Visits. 100% after Deductible has been met for Specialist Care Visits. Network: 100% after Deductible has been met for Primary Care Visits. 100% after Deductible has been met for Specialist Care Visits.	70% after Deductible has been met.
Pregnancy - Maternity Services and Complications of Pregnancy		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	*Prior Authorization is required if Inpatient Stay exceeds 48 hours following an uncomplicated normal vaginal delivery or 96 hours following an uncomplicated cesarean section delivery.*

ADDITIONAL CORE BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Prosthetic Devices for other than Arms and Legs		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years. Once this limit is reached, Benefits, including breast prosthetics, continue to be available for items required by the Women's Health and Cancer Rights Act of 1998. Breast prosthetics are not limited, however the cost of breast prosthetics is applied to the maximum.	100% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required for Prosthetic Devices in excess of $1,000.*
Reconstructive Procedures		
For Covered Persons under the age of 18, Benefits are provided for the reconstructive procedures for craniofacial abnormalities.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Prior Authorization is required.*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of Manipulative Treatments 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy	100% after you pay a $20 Copayment per visit.	70% after Deductible has been met. *Prior Authorization is required for certain services.*
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy Sigmoidoscopy Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	100% after Deductible has been met.	70% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	100% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*

Types of Coverage	Network Benefits	Non-Network Benefits
rgery - Outpatient		
	100% after Deductible has been met. *Prior Authorization is required for certain services.*	70% after Deductible has been met.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis Intravenous chemotherapy or other intravenous infusion therapy Radiation oncology	100% after Deductible has been met. *Prior Authorization is required for certain services.*	70% after Deductible has been met.
Transplantation Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. For Network Benefits, services must be received at a Designated Facility. We will refer you to the Designated Facility most suitable, in our opinion, to treat your condition. In the event that the selected Designated Facility is located outside of Texas and you do not wish to travel outside the state, we shall refer you to an alternate Designated Facility within the State of Texas. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits. *Prior Authorization is required.*	*Prior Authorization is required.*

STATE SPECIFIC BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Acquired Brain Injury		
Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Outpatient Post-Acute Care, Transitional Services and Rehabilitative Services	100% after you pay a $20 Copayment per visit.	70% after Deductible has been met. *Prior Authorization is required as described in your Schedule of Benefits.*
Amino Acid-Based Elemental Formulas		
If an Outpatient Prescription Drug Rider is included under this Policy, Benefits for the amino acid-based elemental formulas will be provided as described under the Outpatient Prescription Drug Rider. Benefits will be provided as specified under this Benefit category: If there is not an Outpatient Prescription Drug Rider included under the policy or if any medically necessary services are provided in connection with the administration of the formula.	100% after Deductible has been met.	70% after Deductible has been met. *Prior Authorization is required.*
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer or other life-threatening disease or condition Cardiovascular (cardiac/stroke) Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. *Prior Authorization is required.*	*Prior Authorization is required.*
Developmental Delay Services (For Groups of 51 or more employees)		
Benefits are paid at the same level as Benefits for any other Covered Health Service, except that the Benefit limit for Rehabilitation Services - Outpatient Therapy and Manipulative Treatment does not apply to services for developmental delays.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Mental Health Services		
	Inpatient: 100% after Deductible has been met. Outpatient: 100% after you pay a $20 Copayment per visit.	Inpatient: 70% after Deductible has been met. Outpatient: 70% after Deductible has been met. *Prior Authorization is required for certain services.*

Types of Coverage	Network Benefits	Non-Network Benefits
Neurobiological Disorders – Autism Spectrum Disorder Services		
	Inpatient: 100% after Deductible has been met. Outpatient: 100% after you pay a $20 Copayment per visit.	Inpatient: 70% after Deductible has been met. Outpatient: 70% after Deductible has been met. *Prior Authorization is required for certain services.*
Orthotic Devices and Prosthetic Devices - for Artificial Arms and Legs		
	100% after Deductible has been met.	70% after Deductible has been met.
Substance Use Disorder Services (includes Chemical Dependency services as required under State of Texas Insurance law and/or regulation)		
	Inpatient: 100% after Deductible has been met. Outpatient: 100% after you pay a $20 Copayment per visit.	Inpatient: 70% after Deductible has been met. Outpatient: 70% after Deductible has been met. *Prior Authorization is required for certain services.*
Temporomandibular Joint Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Request for Pre-authorization of Services required.*

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents shall prevail. It is recommended that you review these documents for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

EXCLUSIONS

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of acute traumatic Injury, cancer or cleft palate. Services required by a Covered Person who is unable to undergo dental treatment in an office setting or under local anesthesia because of a documented physical, mental or medical reason. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to orthotic devices as described under Prosthetic Devices and Orthotic Devices - Artificial Arms and Le in Section 1 of the COC. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cu monitor; enuresis alarm; non-wearable external defibrillator; trusses and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. Oral appliances for snoring. Repairs to prosthetic or orthotic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic or orthotic devices due to misuse, malicious damage or gross neglect or to replace lost items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to prescription and non-prescription oral agents for controlling blood sugar levels. Note: If an Outpatient Prescription Drug Rider is included under the Policy, Benefits for the prescription and non-prescription oral agents will be provided under the Outpatient Prescription Drug Rider. Otherwise, the Benefits will be provided under the Certificate. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to self-injectable medications for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter drugs and treatments for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Growth hormone therapy.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes. Shoe orthotics. This exclusion does not apply to podiatric appliances or therapeutic footwear as described under Diabetes Services or Prosthetic Devices and Orthotic Devices - Artificial Arms and Legs in Section 1 of the COC. Shoe inserts and arch supports.

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Mental retardation or autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Please Note: This Mental Health exclusion section excludes Autism Spectrum Disorders because treatment for Autism Spectrum Disorders are not covered/provided under the Mental Health Services benefit section of Section 1: Covered Health Services. Instead, Benefits for Autism Spectrum Disorder as a primary diagnosis are described under Neurobiological Disorders - Autism Spectrum Disorder Services in Section 1 of the COC. Services or supplies for the diagnosis or treatment of Mental Illness, that in our reasonable judgment, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with our level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Neurobiological Disorders – Autism Spectrum Disorders

Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services. Mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Services as treatment of learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias. Services or supplies for the diagnosis or treatment of Mental Illness that, in our reasonable judgment, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with our level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC. Infant formula and donor breast milk. This exclusion does not apply to amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to:

- Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in Section 1 of the COC, which meet the definition of a Covered Health Service.
- Amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the COC.
- Formulas for phenylketonuria (PKU) or other heritable diseases.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorders. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. This exclusion does not apply when the service is rendered with the diagnosis of acquired brain injury. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

vices performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. This exclusion does not apply to dentists. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization.

Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness, or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in reasonable judgment, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
- Not consistent with our level of care guidelines or best practices as modified from time to time.
- Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

chase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or

other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canal preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions. Routine vision examinations, including refractive examinations to determine the need for vision correction.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

UnitedHealthcare®

YOUR BENEFITS

Benefit Summary

Outpatient Prescription Drug

Texas
10/30/50 Plan 0NN
10/100/300

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - Network and Non-Network

Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Maximum - Network and Non-Network

Individual Out-of-Pocket Maximum	See Medical Benefit Summary
Family Out-of-Pocket Maximum	See Medical Benefit Summary

Benefit Plan Copayment/Coinsurance - The amount you pay.

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	**$10**	**$10**	**$25**
Tier 1 Specialty	**$10**	**$10**	**Not Covered****
Tier 2	**$30**	**$30**	**$75**
Tier 2 Specialty	**$100**	**$100**	**Not Covered****
Tier 3	**$50**	**$50**	**$125**
Tier 3 Specialty	**$300**	**$300**	**Not Covered****

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

** Maximum Network Coverage for Specialty Prescription Drug Products dispensed through Designated Pharmacy. See Designated Pharmacies section of your Outpatient Prescription Drug Rider.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

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UnitedHealthcare Insurance Company

Other Important Information about your Outpatient Prescription Drug Benefits

Note: If you purchase a Prescription Drug Product from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug Product dispensed by a Network Pharmacy.

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Supply limits apply to Specialty Prescription Drug Products whether obtained at a retail pharmacy or through a mail order pharmacy.

Some Prescription Drug Products or Pharmaceutical Products for which Benefits are described under the Prescription Drug Rider or Certificate are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

Also note that some Prescription Drug Products require that you obtain prior authorization from us in advance to determine whether the Prescription Drug Product meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

If you require certain Prescription Drug Products including Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

PHARMACY EXCLUSIONS

Exclusions from coverage listed in the Certificate apply also to this Rider. In addition, the exclusions listed below apply.

Exclusions

- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will not apply to drugs prescribed to treat a chronic, disabling, or life-threatening illness if the drug is both of the following: Has been approved by the Food and Drug Administration for at least one indication. Is recognized for treatment of the indication for which the drug is prescribed in either of the following: A prescription drug reference compendium approved by the commissioner of the Texas Department of Insurance. Substantially accepted peer-reviewed medical literature.
- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in your Certificate. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drug Products.
- Medications used for cosmetic purposes.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products when prescribed to treat infertility.
- Prescription Drug Products for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury. This exclusion does not apply to: Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in Section 1 of the Certificate, which meet the definition of a Covered Health Service. Amino acid-based elemental formulas as described under Amino Acid-Based Elemental Formulas in Section 1 of the Certificate. Formulas for phenylketonuria (PKU) or other heritable diseases.
- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

PHARMACY EXCLUSIONS CONTINUED

- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calen year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

UnitedHealthcare®

dental plan

Options PPO 30/covered dental services

P8730 /U90

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Annual Maximum Benefit *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1500 per person per calendar year	$1500 per person per calendar year	$1500 per person per lifetime	$1500 per person per lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No			
Annual Deductible Applies to Orthodontic Services	No			
Waiting Period	No waiting period			
Orthodontic Eligibility Requirement	Up to age 19			

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Dental Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations *(Amalgam or Anterior Composite)**	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services *(including Emergency Treatment)*	80%	80%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: when clinically necessary. Occlusal Guard: Limited to 1 guard every consecutive 36 months.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Periodontics	80%	80%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Endodontics	80%	80%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
MAJOR DENTAL SERVICES			
Oral Surgery *(includes surgical extractions)*	50%	50%	
Inlays/Onlays/Crowns*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

** The network percentage of benefits is based on the discounted fee negotiated with the provider.

*** The non-network percentage of benefits is based on the schedule of usual and customary fees in the geographic area in which the expenses are incurred.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental® Options PPO Plan is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppage, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United HealthCare Services, Inc.

UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

A. Necessary;

B. Proviced by or under the direction of a Dentist or other appropriate provider as specifically described;

C. The least costly, clinically accepted treatment; and

D. Not excluded as described in the Section entitled, General Exclusions.

GENERAL LIMITATIONS

PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

RESTORATIONS Multiple restorations on one surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

INLAYS AND ONLAYS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy.

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.

OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.

FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

GENERAL ANESTHESIA Covered only when clinically necessary.

OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

GENERAL EXCLUSIONS

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any dental procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the Policy.
10. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
12. Foreign Services are not covered unless required as an Emergency.
13. Replacement of complete dentures, fixed and removable partial dentures, or crowns, if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
15. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
16. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Placement of dental implants, implant-supported abutments and prostheses
18. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
19. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
20. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
21. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
22. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
24. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
25. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
26. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
27. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

Basic Life Benefit Summary

For Eligible Employees

The Accidental Death and Dismemberment (AD&D) portion is automatically included with Basic Life and provides the employee with additional insurance coverage for the loss of life or injuries sustained in an accident on or off the job.*

Coverage	Benefit	Definition
Flat Amount	$25,000	The Life Insurance Benefit Amount.
Guarantee Issue	$25,000	Amount of benefit guaranteed. Benefits over this amount are subject to proof of good health. Evidence of Insurability must be submitted and approved.
Accelerated Benefit	Included	This benefit provides an advanced payout of benefits for covered persons who are terminally ill and not expected to live for more than one year. The benefit pays 50% not to exceed $50,000 of life insurance to the employee.
Waiver of Premium	Included	If eligible employee becomes totally disabled before age 60, life premiums will be waived and life coverage continued until age 65 [annual proof of disability required].
Age Reduction Schedule	65%@65, 50%@70	The benefits will be reduced to 65% of original amount at age 65 and 50% of the original amount at age 70.
Premium Contribution	Non-Contributory	Non-Contributory is when the employer pays 100% of the premium.

✓ Accelerated Death Benefit, Waiver of Premium and Conversion are included.

Value-Added Services (All features may not apply. Some states may have restrictions.)

- **Beneficiary Services:** Provides beneficiaries with services for grief consultation, financial/legal assistance and referral to community resources. **For more information, call 866-302-4480.**
  - •Toll-free line available 24/7 as well as referrals for face-to-face counseling. Specialists provide in-depth consultation, information and referral to community resources such as grief support groups. Includes access to a national network of credentialed clinicians for grief and loss counseling. Beneficiaries receive two complimentary sessions.**
  - •Financial and Legal Services. Telephonic access to financial consultants for assistance with financial decision-making. Includes access to a network of 22,000 attorneys for either a 30-minute telephonic or an in-person consultation. You may retain the same attorney for representation at a discount to their hourly rate. Access to legal services facilitated by CLC, Inc.
  - •Communication Support. We provide a "Beneficiary Kit" with informational resources to help beneficiaries with the emotional and financial process that follows the loss of a loved one.
- **Travel Assistance:** Assists domestic and foreign travelers with a variety of emergency travel-related services, such as medical assistance, emergency transportation and pre-trip information. Includes access to OnCall Travel Assistance customer service center via toll-free or collect telephone call or the Internet, available 24/7 from anywhere in the world. Covers up to 90 days on any one trip when traveling 100+ miles from home or office. **For more information, please call 866-509-7709 or visit http://uhc.cc.oncallinternational.com.** Services provided by OnCall International.

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- **Wealth Management Account:** An enhanced benefit payment process. Life claim proceeds in excess of $5,000 will automatically be deposited into an Optum Bank Wealth Management Account (WMA). Beneficiaries receive an FDIC-insured, beneficiary-owned, interest earning account with convenient access to their claim proceeds via debit card or checkbook.***

- **Will & Trust Preparation Services:** Provides information on will & trust preparation and services. **For more information, please call 800-773-0888 or visit** www.CLClegalforms.com. Services provided by CLC.

Additional Notes:

- *The Accidental Death and Dismemberment Benefit is equal to the Life Benefit; refer to the Certificate of Coverage for the complete AD&D Benefit schedule. Coverage includes a 10% Air Bag and Seat Belt Benefit.
- **Beneficiary Services offered thru United Behavioral Health, a company of UnitedHealth Group.
- ***Eligibility for automatic deposit into an Optum Bank Wealth Management Account is subject to qualifying conditions evaluated by Optum Bank and UnitedHealthcare at the time of claim review to include limited availability in certain states. For more information please contact your UnitedHealthcare representative. Optum Bank, Member FDIC, is part of the financial services unit of OptumHealth, a health and wellness company serving more than 60 million people. Optum is a UnitedHealth Group (NYSE:UNH) company.
- Limitations for AD&D: Disease, bodily or mental infirmity, suicide or intentionally self-inflicted injury, commission of an assault or felony, war, use of any drug unless prescribed by physician, driving while intoxicated, engaging in any hazardous activities, or travel in a private aircraft. Additional exclusions may apply depending upon the plan design of the employer.
- Benefit provisions, exclusions and limitations may vary as a result of state specific requirements.
- Premiums may vary by age.
- The Policy will continue, upon timely payment of premium, unless we cancel because the Policyholder did not meet his obligations stated in the Policy, including providing information needed to administer the Policy, or the participation level drops below the level stated in the Policy.
- Individual coverage will continue, upon timely payment of premium, unless terminated because the Covered Person's insurance under the Policy terminates, or the dependent no longer meets the specific eligibility requirements stated in the Policy or the Policy terminates.
- UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company; Unimerica Insurance Company; in California by Unimerica Life Insurance Company; and in New York by Unimerica Life Insurance Company of New York. Texas coverage is provided on Form LASD-POL -TX (05/03), Form UHCLD-POL 2/2008-TX, or Form UICLD-POL -TX 4/5. UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Insurance Company and Unimerica Life Insurance Company in Milwaukee, WI; and Unimerica Life Insurance Company of New York in New York, NY.
- This Benefit Summary is intended only to highlight benefits and should not be relied upon to fully determine coverage. More complete descriptions of benefits and the terms under which they are provided are contained in the Certificate of Coverage received upon enrollment in the plan. If this Benefit Summary conflicts in any way with the Policy issued to the employer, the Policy shall prevail.

Financial Protection

Life insurance

Will and trust preparation services

Preparing a will is one of the most important things you can do for your loved ones. But some people don't consult with an attorney because of the cost. And they're not sure how else to handle their estate planning responsibilities.

That's why at UnitedHealthcare, we offer life insurance products with an added benefit: will and trust preparation services. With these services, you can access a wealth of estate planning information online, use financial calculators, download legal forms and use a will-preparation tool that allows you to prepare your own official legal documents.

Program overview.

Our will and trust preparation services, which are provided by Consolidated Legal Concepts, Inc. (CLC), are available to all members covered by our life insurance products at no additional premium cost. Members interested in using assisted document-preparation services may incur a minimal cost.

In brief:

- Will and trust preparation assistance is an added benefit of your UnitedHealthcare life insurance plan
- Access a wealth of information on estate planning and use online tools to prepare legal documents
- To access, visit clcmembers.com

UnitedHealthcare®

Through CLC, you have access to the following resources:

- **Legal library:** Educational articles on a wide range of legal and financial topics, as well as attorneys' answers to frequently asked questions[1]
- **Legal forms:** Standard legal forms for each state covering various legal situations, including estate planning, wills and trusts, living wills and power of attorney
- **Legal tools:** A self-directed will and trust preparation tool that enables you to create legal documents — including a will or power of attorney — in less than an hour. Documents can be stored online so you can access and update them in the future (registration required)
- **Assisted document preparation:** Get discounted document-preparation assistance from one of the leading national document-preparation companies (fee required).[2] To take advantage of discounted prices on document preparation, call **1-800-773-0888** and identify yourself as a member of CLC.[3] Your discount code is **CLC888**

Easy online access to a wealth of information.

To access the will and trust preparation services, visit:

- **clcmembers.com**

  Username: **uhc**

  Password: **legal**

The CLC Legal Resource Center will be displayed, allowing you to access articles, forms, legal and financial tools and more.

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[1]Online reference material provided by CLC, Inc.

[2]Users receive a 10% discount on assisted document-preparation fees. The fee must be paid online with a credit card to initiate the document-preparation process.

[3]Employees interested in assisted document-preparation services may incur a minimal cost.

UnitedHealthcare Life products are provided by UnitedHealthcare Insurance Company; and in California by Unimerica Life Insurance Company; and in New York by Unimerica Life Insurance Company of New York. UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Life Insurance Company is located in Milwaukee, WI; and Unimerica Life Insurance Company of New York is located in New York, NY.

Specialty benefits and programs may not be available in all states or for all group sizes. Components are subject to change.

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Financial Protection

Life insurance

Beneficiary Services

When a loved one dies, the resulting emotional, financial and legal issues can feel overwhelming. To provide extra support at a difficult time, UnitedHealthcare offers a Beneficiary Services program to beneficiaries of its life insurance plans and their dependents. The program is available as a value-added service provided at no extra premium cost.

Program overview.

The Beneficiary Services program provides access to support services to help you deal with your loss and manage your affairs:

- **Toll-free Beneficiary Services line:** Unlimited phone access to a master's-level counselor, 24 hours a day, 7 days a week
- **Referral for face-to-face counseling:** Referral to a national network of licensed and certified clinicians for up to two grief counseling sessions
- **Financial services:** Free 30 minute telephonic consult with a financial coach per year/per topic
- **Legal services:** Free 30-minute telephone or in-person consultation with an attorney for help with wills, probate or other legal concerns. You may retain the same attorney for representation at a discount to their hourly rate.
- **Information and referral:** Referral to community resources, such as grief support groups, from a database of over 100,000 contacts

Beneficiary Services
1-866-302-4480

- Dedicated toll-free phone line for confidential assistance
- TDD/TTY line for people who are hearing- or speech-impaired
- Translators available for non-English speakers

Maintaining your privacy and confidentiality is of utmost importance. All records, referrals and evaluations are kept private in accordance with federal and state laws.

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