UnitedHealthcare

Benefit Summary

Texas - Insurance Choice Plus
Premier - Plan AGZP

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health services, when possible.

What are the benefits of the UnitedHealthcare Tiered Benefit Plus Plan?

Get more protection with a national network and save with Tier 1 providers.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care from anyone in or out of our network, but you can save more money when you use the network. You can save even more when you use UnitedHealth Premium® Tier 1 providers.

> **Pay less by using UnitedHealth Premium Tier 1 providers.** They have been recognized for providing value.

> **There's coverage if you need to go out of the network.** Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember out-of-network providers will likely charge you more.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

Not enrolled yet? Search for network doctors or hospitals at **welcometouhc.com** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me™** mobile app.

For questions, call the member phone number on your health plan ID card.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
$20	$250	You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Insurance Company

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Deductible		

What is a deductible?

The deductible is the amount you have to pay for covered health care services (common medical event) before your health plan begins to pay. The deductible may not apply to all services. You may have more than one type of deductible.

> Your co-pays don't count towards meeting the deductible unless otherwise described within the specific common medical event.

> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

Medical Deductible - Individual	$250 per year	$5,000 per year
Medical Deductible - Family	$500 per year	$10,000 per year

Out-of-Pocket Limit

What is an out-of-pocket limit?

The most you pay during a policy year before your health plan begins to pay 100%. Once you reach the out-of-pocket limit, your health plan will pay for all covered services. This will not include any amounts over the amount we allow when you see an out-of-network provider.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

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

What is co-insurance?

Co-insurance is your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A co-payment (co-pay) is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. You will pay a co-pay or the allowed amount, whichever is less. The amount can vary by the type of covered health care service. Please see the specific common medical event to see if a co-pay applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you can get access to medicine or services. Services that require prior authorization are noted in the list of Common Medical Events. To get approval, call the member phone number on your health plan ID card.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Acquired Brain Injury		
Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	The amount you pay is based on where the covered health service is provided.	
Outpatient Post-Acute Care, Transitional Services and Rehabilitative Services	$20 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Ambulance Services - Emergency and Non-Emergency		
	You pay nothing, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.	You pay nothing, after the network medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
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.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Autism Spectrum Disorder Services		
	The amount you pay is based on where the covered health service is provided.	Prior Authorization is required for certain services.
Clinical Trials		
	The amount you pay is based on where the covered health service is provided. Prior Authorization is required.	Prior Authorization is required.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Congenital Heart Disease (CHD) Surgeries		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Dental Services - Accident Only		
	You pay nothing, after the medical deductible has been met. Prior Authorization is required.	You pay nothing, after the network medical deductible has been met. Prior Authorization is required.
Developmental Delay Services		
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.	The amount you pay is based on where the covered health service is provided.	
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Examinations/ Foot Care:	The amount you pay is based on where the covered health service is provided.	
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.	The amount you pay is based on where the covered health service is provided under Durable Medical Equipment or in the Prescription Drug Rider.	Prior Authorization is required for diabetes equipment in excess of $1,000.
Durable Medical Equipment		
Limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every 3 years. This limit does not apply to wound vacuums.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Durable Medical Equipment that costs more than $1,000.
Emergency Health Services - Outpatient		
	$300 co-pay per visit. A deductible does not apply.	$300 co-pay per visit. A deductible does not apply. Notification is required if confined in an Out-of-Network Hospital.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Hearing Aids		
Limited to a single purchase (including repair and replacement) per hearing impaired ear every 3 years.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Home Health Care		
Limited to 60 visits per year.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Hospice Care		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for Inpatient Stay.
Hospital - Inpatient Stay		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Human Papillomavirus and Cervical Cancer Screenings		
	You pay nothing. A medical deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Lab, X-Ray and Diagnostics - Outpatient		
	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical 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		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required.
Mental Health Services and Serious Mental Health Services		
Inpatient:	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$20 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met. Prior Authorization is required for certain services.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Neurobiological Disorders – Autism Spectrum Disorder Services		
Inpatient:	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$20 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Orthotic Devices and Prosthetic Devices - for Artificial Arms and Legs		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Osteoporosis Detection and Prevention		
	The amount you pay is based on where the covered health service is provided.	
Ostomy Supplies		
Limited to $2,500 per year.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications given at a doctor's office, or in a Covered Person's home.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Phenylketonuria and Other Heritable Diseases		
	The amount you pay is based on where the covered health service is provided.	
Physician Fees for Surgical and Medical Services		
	Designated Network: You pay nothing for primary care visits, after the medical deductible has been met. You pay nothing for specialist care visits, after the medical deductible has been met. Network: You pay nothing for primary care visits, after the medical deductible has been met. You pay nothing for specialist care visits, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit A deductible does not apply to 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: You pay nothing. A deductible does not apply. All other Covered Persons: Designated Network: $20 co-pay per visit. A deductible does not apply. Network: $20 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Specialist Physician Office Visit A deductible does not apply to necessary diagnostic follow-up care relating to the screening test for hearing loss of newborn Dependents, from birth through 24 months.	Designated Network: $20 co-pay per visit. A deductible does not apply. Network: $40 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery.		
Pregnancy - Maternity Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required if the stay in the hospital is longer than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Prescription Drug Benefits		
Prescription drug benefits are shown in the Prescription Drug benefit summary.		
Preventive Care Services		
Physician Office Services, Scopic Procedures, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Childhood Immunizations	You pay nothing. A medical deductible does not apply.	You pay nothing. A medical deductible does not apply.

Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Prosthetic Devices for other than Arms and Legs		
Benefits for Prosthetic Devices for Artificial Arms and Legs can be found under Orthotic Devices and Prosthetic Devices - Artificial Arms and Legs.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for Prosthetic Devices that costs more than $1,000.
Reconstructive Procedures		
No coverage for cosmetic procedures, except for craniofacial abnormalities for children under age 18.	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required.
Rehabilitation and Habilitative Services - Outpatient Therapy and Manipulative Treatment		
Limited to: 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. 20 visits of manipulative treatments.	$20 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Limited to 60 days per year.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required.

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Substance Use Disorder Services and Chemical Dependency Services		
Inpatient:	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
Outpatient:	$20 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Surgery - Outpatient		
	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Temporomandibular Joint Services		
	The amount you pay is based on where the covered health service is provided.	
		Prior Authorization is required for Inpatient Stay.
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.	30% co-insurance, after the medical deductible has been met.
		Prior Authorization is required for certain services.
Transplantation Services		
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.	The amount you pay is based on where the covered health service is provided.	
	Prior Authorization is required.	Prior Authorization is required.

Your Costs

Common Medical Event	Your cost if you use Network Benefits	Your cost if you use Out-of-Network Benefits
Urgent Care Center Services		
	$75 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.
Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery.		
Virtual Visits		
Network Benefits are available only when services are delivered through a Designated Virtual Visit Network Provider. Find a Designated Virtual Visit Network Provider Group at myuhc.com or by calling Customer Care at the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	$20 co-pay per visit. A deductible does not apply.	30% co-insurance, after the medical deductible has been met.

Services your plan does not cover (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 Orthotic Devices and Prosthetic Devices for Artificial Arms and Legs in Section 1 of the COC. Cranial banding. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/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 or stolen 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. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

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 Orthotic Devices and Prosthetic Devices - for 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.

Services your plan does not cover (Exclusions)

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 R & T 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-wake disorders, feeding disorders, binge eating disorders, sexual dysfunction, communication disorders, motor 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 paraphilic disorder. Educational 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. Motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Intellectual disabilities as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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: The Mental Health exclusion section excludes Autism Spectrum Disorders because treatment for Autism Spectrum Disorders are not covered/provided under the Mental Health Services in section 1 of the COC. 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. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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 in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Neurobiological Disorders – Autism Spectrum Disorder

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. Intellectual disability 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 disorders and 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 paraphilic disorder. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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 in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

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.

Services your plan does not cover (Exclusions)

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 Disorder. 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. This exclusion does not apply to Benefits described under Temporomandibular Joint Syndrome in Section 1 of the COC. 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 surgery except as coverage is required by the Women's Health and Cancer Rights 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

Services 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. This exclusion does not apply to dentists. 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 services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. 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 in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

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

Purchase 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 canals 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 an Out-of-Network provider waives co-payments, co-insurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance 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.

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TX DOI Form CCOV.I.16.TX UnitedHealthcare Insurance Company

UnitedHealthcare

Benefit Summary

Outpatient Prescription Drug

Texas, Plan NN

Standard Drugs: 10/30/50 Specialty Drugs: 10/100/300

Your Co-payment and/or Co-insurance 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 Limit - Network	
Individual Out-of-Pocket Limit	See Medical Benefit Summary
Family Out-of-Pocket Limit	See Medical Benefit Summary

Out-of-Pocket Limit does not apply Non-Network.

Benefit Plan Co-payment/Co-insurance - 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

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 Co-payment and/or Co-insurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Co-payment and/or Co-insurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Co-payment and/or Co-insurance, 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.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program each year through the Internet at myuhc.com or by calling Customer Care at the telephone number on your ID card.

Certain Preventive Care Medications maybe covered. Log on to www.myuhc.com or call the Customer Care number on your ID card for more information.

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 or repackagers 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.
- Certain 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 contain a non-FDA approved bulk chemical. 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 or supplement. 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. This exclusion does not apply to over-the-counter items for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- 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 and prescription medical food products, 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.

PHARMACY EXCLUSIONS CONTINUED

- 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.
- 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 calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.

Packaged Savings®

Bundle your benefits for savings and simplicity

For groups of 2-99 total eligible medical employees

Packaged Savings means:

- Bundled UnitedHealthcare medical and specialty benefits for administrative credit
- Savings based on medical enrollment and the number of eligible employer paid or contributory specialty coverages chosen
- One account team from UnitedHealthcare to serve all of your benefits needs
- Streamlined administration
- State-of-the-art online employer tools

For new medical and eligible specialty groups, medical groups adding new eligible specialty coverage, or eligible stand-alone specialty groups adding medical coverage.

Credits are available as long as eligible benefits remain in-force. Credits will be withdrawn when any medical or specialty coverages terminate or when a customer does not meet participation requirements. Program is subject to change at any time.

Buy your medical plan and specialty benefits together and save.

UnitedHealthcare gives you one-stop shopping for quality, comprehensive health care benefits. You can combine our innovative, affordable medical plans with comprehensive specialty benefits – dental, life, disability and vision.

When you bundle your benefits, you can expect proven knowledge and service from a leading specialty carrier plus the simplicity and convenience of just one team to administer your benefits. The savings you realize through Packaged Savings are based upon medical enrollment and the number of active lines of specialty coverage you have with UnitedHealthcare. The more you bundle, the more you save.

When your group purchases medical and:	Receive the following potential savings calculated per employee per month:
Dental	$3.00
Vision	$2.00
Life[1]	$1.00
Short-term disability[2]	$1.00
Life[1] and short-term disability	$2.00
Life[1] and long-term disability[2]	$2.00
Dental and vision	$5.00
Dental and life	$4.00
Vision and life[1]	$3.00
Dental, vision and life[1]	$6.00
Dental, vision, life[1] and short-term disability[2]	$7.00

[1]Any combination of life products counts as one product for the purpose of the program.

[2]Any combination of disability products counts as one product for the purposes of the program.

Long-term disability must be bundled in conjunction with life or short-term disability coverage to qualify for the program and be eligible for credit.

Per-employee per-month savings is given as a monthly credit based on the number of enrolled UnitedHealthcare medical subscribers.

Simpler processes, smarter solutions, better results for you.

For more information on the Packaged Savings program from UnitedHealthcare, please contact your UnitedHealthcare representative.

Program terms and conditions

1. The Packaged Savings program is available to all new or existing medical and specialty business with 2 - 99 total eligible employees or to existing medical policies adding new specialty lines of coverage.
2. The applied savings is available for as long as eligible medical and specialty benefits remain in-force and meet eligibility requirements. Credits will be withdrawn when any medical or specialty coverages terminate. Program is subject to change at any time.
3. Per-employee per-month (PEPM) savings is given as a monthly credit based on the number of enrolled UnitedHealthcare medical subscribers.
4. Voluntary specialty benefit plans do not qualify for the Packaged Savings program.
5. Employer-paid plans require an employer contribution level of 50 percent or greater. Participation in qualifying dental and vision plans must meet and maintain 75 percent or greater of eligible medical employees for Packaged Savings to be active.
6. Life insurance plans qualifying for Packaged Savings must completely replace existing life plans or be added to customers with no prior coverage; adding an additional life policy to an existing life benefit does not qualify for Packaged Savings.
7. Customers who have existing basic and supplemental life with another carrier must place both the basic and supplemental life with UnitedHealthcare to qualify for Packaged Savings.
8. Any combination of life products counts as one product for the purpose of the program. Any combination of disability products counts as one product for the purpose of the program. Long-term disability does not qualify alone; it must be packaged with life or short-term disability.
9. Customers with fully insured medical benefits must also purchase fully insured specialty benefits to qualify.
10. Customers who add UnitedHealthcare medical products to existing dental, vision, life and/or disability lines of coverage qualify for Packaged Savings (a.k.a Reverse Packaged Savings).
11. Specialty benefits can be added off-cycle from the existing medical or specialty benefit effective date and will become eligible for Packaged Savings as long as medical coverage remains in force and products meet eligibility requirements.
12. UnitedHealthcare retains sole and complete discretion to revise or terminate the Packaged Savings program at any time.
13. The policies referred to have exclusions, limitations, reductions of benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of coverage, please contact your UnitedHealthcare representative.
14. The following business is currently excluded from the Packaged Savings program: business underwritten or administered by Oxford Health Plans, Sierra Health Services Inc. and LIVE! platform dental and life (unless sold with LIVE! platform medical coverage).
15. The Specialty Benefit Solutions (SBS) product is not an eligible coverage for the UnitedHealthcare Packaged Savings program.
16. Not all specialty benefits are available in all states or for all group sizes. Contact your UnitedHealthcare sales representative for specialty product availability.
17. Packaged Savings may not be available in all states or for all group sizes. Contact your UnitedHealthcare sales representative for program availability.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by UnitedHealthcare Insurance Company, United HealthCare Services, Inc. or their affiliates.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06 and associated COC form number VCOC.INT.06.TX.

UnitedHealthcare Life and Disability 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. In Texas coverage is provided on Form LARD-POL-TX (05/03) or Form UHCLD-POL 2/2008-TX. UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Life Insurance Company in Milwaukee, WI; Unimerica Life Insurance Company of New York in New York, NY.

UnitedHealthcare Dental coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by Dental Benefit Providers, Inc., Dental Benefit Administrative Services (CA only), United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number DPOL.06 TX (11/15/2008) and associated COC form number DCOC.CER.06.

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

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LIFE PRODUCT DESCRIPTION & PREMIUM

POLICY NUMBER: 0TU6814
POLICYHOLDER NAME: LAGUNAMADREWATERDISTRICT

RENEWAL DATE: 10/01/16
OUTPUT DATE: 10/01/16

CURRENT INFORMATION COVERAGE	BENEFIT	ENROLLMENT	VOLUME	RATE	MONTHLY PREMIUM
LIFE INSURANCE	$ 25,000	74	$ 1,832,500	$ .15 PER $1000	$ 274.88
AD&D INSURANCE			$ 1,832,500	$ .02 PER $1000	$ 36.64
TOTAL					$ 311.52

RENEWAL INFORMATION COVERAGE	BENEFIT	ENROLLMENT	VOLUME	RATE	MONTHLY PREMIUM
LIFE INSURANCE	$ 25,000	74	$ 1,832,500	$ .15 PER $1000	$ 274.88
AD&D INSURANCE			$ 1,832,500	$ .02 PER $1000	$ 36.64
TOTAL					$ 311.52

QUOTE ASSUMPTIONS:

- THE BASIC LIFE/AD&D AND BASIC DEPENDENT LIFE PLANS HAVE A 24 MONTH GUARANTEE.THE RATES WILL BE IN EFFECT THROUGH 09/30/18
- UNITEDHEALTHCARE INSURANCE COMPANY IS THE SOLE CARRIER FOR LIFE COVERAGE
- ALL COVERAGE TERMINATES AT RETIREMENT

THIS IS A HIGH LEVEL BENEFIT SUMMARY. FURTHER DETAILS CAN BE FOUND IN THE CERTIFICATE OF COVERAGE. STATE LAW MAY SUPERCEDE CERTAIN OF THESE PROVISIONS.

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.

Basic Life Benefit Summary

- **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.

UnitedHealthcare®

DENTAL PLAN OPTIONS & PREMIUM

POLICY NUMBER: 01U6814
POLICYHOLDER NAME: LAGUNAMADREWATERDISTRICT

RENEWAL DATE: 10/01/16
OUTPUT DATE: 10/01/16

PLANS	CURRENT
PLAN CODES	P8730
PLAN TYPE	DPPO
DEDUCTIBLE (IND/FAM)	$ 50/$ 150
PREVENTATIVE COINS IN/OUT NET	100%/100%
MINOR RESTOR COINS IN/OUT NET	80%/ 80%
ENDO, PERIO, ORAL SURGERY COINS IN/OUT NET	80%/ 80%
MAJOR SERVICES COINS IN/OUT NET	50%/ 50%
ANNUAL PLAN MAXIMUM IN/OUT NET	$1,500/$1,500
ORTHODONTIA BENEFIT	CHILD ONLY
ORTHODONTIA COINS IN/OUT NETWORK	50%/ 50%
ORTHODONTIA LIFETIME MAXIMUM	$1,500
RENEWAL MONTHLY PREMIUM	$ 2,082.51

RENEWAL MONTHLY RATES	# ENROLLED	CURRENT	RENEWAL
EMPLOYEE ONLY	85	$ 22.19	$ 22.19
EMPLOYEE AND SPOUSE	2	$ 44.39	$ 44.39
EMPLOYEE AND CHILD	9	$ 54.92	$ 54.92
EMPLOYEE AND FAMILY	1	$ 81.48	$ 81.48

	NON-ORTHODONTICS NETWORK	NON-ORTHODONTICS NON-NETWORK	ORTHODONTICS NETWORK	ORTHODONTICS 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 [illegible] 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 [illegible] Dental Care (not available in [illegible]) and Oral Cancer Screening programs are included with 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 of 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, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; or United HealthCare Services, Inc.

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UnitedHealthcare/dental exclusions and limitations

GENERAL LIMITATIONS

[illegible]

GENERAL EXCLUSIONS

[illegible]

POLICY NUMBER: 01U6814

POLICYHOLDER NAME: LAGUNAMADREWATERDISTRICT

VISION PLAN OPTIONS & PREMIUM

RENEWAL DATE: 10/01/16

OUTPUT DATE: 10/01/16

PLANS	CURRENT
PLAN CODES	L004V
PLAN TYPE	VOLUNTARY
COPAY	$10/$25
FREQUENCY	12/12/12

RENEWAL MONTHLY PREMIUM $ 405.09

RENEWAL MONTHLY RATES	# ENROLLED	CURRENT	RENEWAL
EMPLOYEE ONLY	15	$ 8.01	$ 8.01
EMPLOYEE AND SPOUSE	7	$ 15.18	$ 15.18
EMPLOYEE AND CHILD	8	$ 17.81	$ 17.81
EMPLOYEE AND FAMILY	5	$ 26.06	$ 26.06

THE VISION PLANS HAVE A 24 MONTH RATE GUARANTEE. THE VISION RATES WILL BE IN EFFECT THROUGH 09/30/17

06 01U6814

Vision Benefit Summary

www.myuhcvision.com

Customer Service: (800) 638-3120

Provider Locator: (800) 839-3242

Plan L004V

	NETWORK	NON-NETWORK
Comprehensive Vision Exam	$10 Copay	Up to $40
Materials - Eyeglass Lenses/Eyeglass Frames or Contact Lenses	$25 Copay[1]	See below
Frequencies - Based on last date of service	Exam Once every 12 months Lenses Once every 12 months Frames Once every 12 months	

COVERED SERVICES	NETWORK	NON-NETWORK
Pair of Lenses (for Eyewear)		
• Standard single vision lenses • Standard lined bifocal lenses • Standard lined trifocal lenses • Standard lenticular lenses Lens options such as progressive lenses, tints, UV, and anti-reflective coating may be available at a discount at participating providers.	Covered in full after applicable copay[1] Includes standard scratch-resistant coating	Up to $40 Up to $60 Up to $80 Up to $80
Frames		
You will receive a retail frame allowance toward the purchase of any frame at a network provider. For frames that exceed your allowance, you may receive an additional 30% discount on the overage (available only at participating providers and may exclude certain frame manufacturers).	$130 Retail Frame Allowance (after applicable copay[1])	Up to $45
Contact Lenses[2]		
• Covered contact lens selection It is important to note the covered contact lens selection may vary by provider but does include the most popular brands on the market today.[3] A complete list can be found by visiting our website www.myuhcvision.com.	Up to 4 boxes of contact lenses plus the fitting/evaluation fees and up to two follow-up visits are covered-in-full (after applicable copay[1])	Up to $125
• Non-selection contacts You receive an allowance which is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered contact lens selection.	Up to $125 (material copay is waived)	Up to $125
• Necessary contact lenses[4]	Covered in full after applicable copay[1]	Up to $210

[1] The material copayment will apply once if frames and lenses, or contact lenses in lieu of eyewear, are purchased at the same time at a network provider.

[2] Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames.

[3] Coverage for Covered Contact Lens Selection does not apply at Walmart, Sam's Club and Costco locations. The allowance for non-selection contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

[4] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or eyeglass frames; with certain conditions of anisometropia, keratoconus, irregular corneal astigmatism, aphakia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare concerning the reimbursement that UnitedHealthcare will make before you purchase such contacts.

www.optumclinic.com

Receive immediate access to care

Optum™ Clinic+ Urgent Care offers a wide range of health care services, including walk-in treatment of illnesses and injuries, on-site labs and X-rays, wellness visits, and occupational health and cosmetic services. We deliver immediate, patient-centric access to care, improving health outcomes at a significant financial savings.

Health care challenges	Solutions from Optum Clinic
• Many patients do not have a primary care provider or prefer same-day access. Consequently, they go to an ER.	• Provide a wide range of health and wellness services at a comparable cost to primary care.
• In 2010, average wait time in a U.S. emergency room was 4 hours, 7 minutes.[1]	• Patients experience little or no wait times, allowing them to get back to work and home life.
• High rate of ER utilization is costly. Average cost of ER visit = $1,316[2]	• Average cost of urgent care visit = $155[3] • Savings of $1,161

Example:
A company with 1,000 employees averages 600 ER visits annually.

If 300 of those ER visits were treated at urgent care rather than ER, there would be a cost savings of $1,161 per patient.[1,2] → Annual reduction in spend of **~$348,300+**

Experience convenient care

We provide personalized medical care to our patients in a soothing environment. Patients are cared for by a staff of experienced medical doctors and advanced practitioners.

- Walk-ins welcome, or schedule a same-day appointment online
- Open extended hours 365 days a year:
  Monday–Friday, 7:30 a.m. to 8 p.m.
  Weekends and holidays, 9 a.m. to 5 p.m.
- Same-day lab and X-ray results available for many diagnoses

Maintain a healthy workforce

We also offer a comprehensive occupational health program that helps achieve your employee health goals. We provide both health and wellness services to help you maintain a safe and healthy workforce, including:

- Treatment of injuries and illnesses
- Screenings (biometric, blood pressure, cholesterol, hearing testing)
- Preemployment physical exams
- On-site labs, testing and X-rays
- Drug testing (non-DOT)
- DOT physicals and drug testing
- Return to work/fitness for duty exams
- Workers' compensation injury care
- Weight management and smoking cessation programs
- Vaccinations
- Wellness events

1 Press Ganey 2010 Emergency Department Pulse Report: Patient Perspectives on American Health Care.
2 Available Emergency Department Usage Analysis ... Health Analytics, Spring 2013 ...
3 The Case for Urgent Care, Urgent Care Association of America, September 1, 2011.

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UnitedHealthcare®

Vision Benefit Summary
www.myuhcvision.com
Customer Service: (800) 638-3120
Provider Locator: (800) 839-3242

Plan L004V

Important to Remember:

Network

- Always identify yourself as a UnitedHealthcare customer when making your appointment. This will assist your provider in obtaining a claim authorization before your visit.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.
- Your contact lens allowance is applied to the fitting/evaluation fees, as well as the purchase of non-covered selection contact lenses. For example, if your allowance is $125 and the fitting fee and evaluation is $35, you will have $90 toward the purchase of non-selection contact lenses. Evaluation and fitting fees may vary among providers and type of fitting required. Your material copay is waived when purchasing non-selection contacts.
- Patient options, such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service, visit our Web site at www.myuhcvision.com or call 1-800-839-3242, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at www.myuhcvision.com.

Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.

Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.

Non-Network Provider - Participant pays full fee to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to non-network benefits. All receipts must be submitted at the same time. Written proof of loss should be given to the Company within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Additional Materials Benefit

UnitedHealthcare offers an additional Materials Discount Program. At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

Customer Service is available toll-free at 1-800-638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

UnitedHealthcare Vision® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX and associated COC form number VCOC.INT.06.TX.

Client Services: Introducing Email Service Team

UnitedHealthcare's Client Service Operations (CSO) has expanded its service model to now include email as an additional option for customer support. Although customers can still use 1-888-UHC-HLP1 for urgent issues that require immediate attention, this new CSO email channel is a convenient option for non-urgent issues. Either way, our Customer Service Professionals are available to help.

Email address

clientserviceoperations@uhc.com

What to expect

The CSO email team will handle the same types of issues currently handled when calling 1-888-UHC-HLP1. The expected turnaround time for the customer to receive a response to an email will be less than 24 hours (except for weekends and holidays). If an email issue cannot be resolved in 24 hours or less, the email team will provide an update with a new expected turnaround time for resolution. Also, a tracking number will be provided for each issue received, if future reference to the issue is needed.

Who can use the email service team

The email team is primarily for brokers/agencies and employer group plan administrators not associated or assigned to a dedicated or designated service model.

Issue types

In scope	Out of scope
• Billing • Eligibility • Claims • Benefit questions (post-installation) • Commissions • Health plan ID cards • Member/subscriber terminations and adds outside the renewal date • Voluntary/group termination • Plan changes with a policy and/or financial impact • Administration kits • COBRA inquiries • FSA/HRA administration inquiries	• Renewals • Group set-up/installation • Pre-sale/new business inquiries, including pricing, network and underwriting

UnitedHealthcare

Care24®

Well-being for work and life

When it comes to their health and well-being, members have questions – How can I find a doctor? Can someone help me lose weight? Can you help me cope with my stress? I need a living will, where do I start? Care24 provides members information to help them make informed decisions about their health and well-being.

Health and well-being concierge – A single point of contact

Care24 is a health and well-being concierge service where members are connected with a single point of contact who guides them to clinical, wellness, financial, legal or counseling resources through NurseLine℠ and Employee Assistance Program (EAP) – 24 hours a day, seven days a week.

NurseLine – Better clinical advocacy helping drive better health outcomes

NurseLine's registered nurses connect members to the Right Treatment, Right Provider, Right Medication and Right Lifestyle by:

- answering questions about an illness or injury
- providing support on managing a chronic condition or assessing treatment options
- identifying UnitedHealth Premium® designation program providers and even schedule appointments
- coaching on medication adherence, drug interactions or medication alternatives
- preventive care information and healthy lifestyle coaching

Creating value with a distinctive call-back model

NurseLine closes gaps in care through a distinctive call-back model where nurses call members to close health opportunities that weren't resolved during the initial call – ultimately driving higher levels of action and creating better health outcomes.

Clinical and navigational advocacy

The NurseLine registered nurses use a clinically sound approach through evidence-based clinical guidelines when interacting with members. Nurses have access to a "whole person" view of the member's health history at the time of the call allowing them to address not only the immediate symptom, but a member's total health status. Integration with other programs helps drive higher referral rates across the continuum of care, including disease management, case management and wellness.[3] Members get to more of the resources they need on a more timely basis.

NurseLine delivers results:

- 2:1 average program return on investment (ROI)[1]
- Avoided Emergency Room (ER) visits for 75% of callers with ER pre-intent[1]
- 28% of callers are referred to a relevant health or wellness program and 38% of those callers enrolled in the program[2]
- 200% increase in number of referrals resulting in successful case management when NurseLine nurses warm transfer the member versus using a data transfer[3]
- NurseLine has a 95% caller satisfaction level[4]

UnitedHealthcare®

What to include

Email submissions must include the following information to be handled efficiently:

- Secure messaging enabled
- Submitter's first and last name – must be in the body of the email or email signature. The email address alone will not be accepted
- Name of agency
- Group name and group number
- Member-related issues: member's first and last name, DOB and alternate ID/SSN
- Detailed description of the issue or inquiry

Our email service channel is one more way to help make it easier for you to do business with us and help you get back to doing what you do best – running your business.

For more information, contact your UnitedHealthcare representative.

UnitedHealthcare®

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

10/12

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UHCEW508065-000

UnitedHealthcare

COBRA Administration, Flexible Spending Accounts, and Pre-Tax Premium Plans

Available for customers with 20-99[1] eligible employees

Save time and money

Lighten your administrative responsibilities by offering:

- COBRA Administration
- Flexible Spending Accounts
- Pre-Tax Premium Plans

When you purchase UnitedHealthcare medical coverage you automatically receive these services at no additional cost to you[1]. Simply log in to **uhcservices.com** to activate your benefits.

Program advantages

- One stop shopping
- Limited employer liability
- Reduction of payroll-related taxes
- Increased employee satisfaction

COBRA administration

COBRA, or the Consolidated Omnibus Budget Reconciliation Act of 1985, enables employees and dependents who no longer qualify under an employer approved group health plan to continue insurance under the group benefit plan.

UnitedHealthcare provides streamlined COBRA administration and efficient record-keeping, which allows you to concentrate on managing your growing business.

Flexible Spending Accounts (FSA)

The Flexible Spending Account portion of Section 125 allows for employee contributions to a dedicated savings account be made on a pre-tax basis, resulting in savings to both employers and employees. Your company's total taxable payroll is reduced, directly lowering payroll-related taxes and your employees reduce their taxable income and pay less in federal, state, Social Security and Medicare taxes.

Pre-Tax Premium

Reduce your total taxable payroll and lower your payroll related taxes by implementing a pre-tax premium plan. Employee Pre-Tax Premium contributions are not considered taxable income under Section 125. Offering your employees a Pre-Tax Premium plan allows them to decrease their taxable income and increase their take-home pay.[2]

Next steps

Visit **uhcservices.com** to activate your account or contact customer service at 1-800-318-5311 or your UnitedHealthcare representative to learn more details on the services available.

To activate your account you will need the following information:

- Employer tax ID number
- Business address
- Carrier/Plan information (for COBRA administration only)
- Bank account information (FSA Administration only)

You can activate your account in five easy steps

1. Log on to **uhcservices.com**
2. Enter your User ID and Password
3. Follow the screen prompts
4. Click on the service you are activating from the blue menu bar and click '*Implement*'
5. Follow the screen prompts

[1] Available to employers with 2-19 employees in select markets. Please check with your UnitedHealthcare representative.

[2] Your company's legal arrangement determines whether you can pay your own premiums on a pre-tax basis.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates.

UnitedHealthcare

100-9212 1/14 Employer © 2014 UnitedHealthCare Services, Inc.

EAP – Increasing workplace efficiency

Care24 provides confidential[5] support to members for those everyday challenges or even for more serious problems, including:

- assistance in dealing with stress, depression and anxiety
- personal financial and legal advice
- parenting and family problems, including dealing with domestic violence
- substance abuse and recovery
- eating disorders

Programs to address workplace concerns

Care24 also provides managers and supervisors with tools that can help keep their work group on track.

- Workplace management consultations – help with complex workplace problems affecting productivity and profitability
- Critical response incidence services – help reduce impact of traumatic workplace events
- Care24 training – encourages your employees to use Care24

Care24 advantages to employers

- Higher productivity – Care24 helps your employees quickly find reliable resources
- Lower absenteeism – Care24's information and education help employees take a proactive approach to staying healthy, which can help them stay on the job.
- Reduced health care expenses – Your employees become smarter health care consumers and make better decisions about seeking an appropriate level of care.

Care24 EAP results[6]:

- 94% of callers reported improved productivity at work
- 45% of callers reported Care24 helped them avoid being absent from work
- 94% of members using the service are satisfied/very satisfied

*Available services will vary by funding type and market segment. Please contact your UnitedHealthcare representative for more details.

1. UnitedHealth Group Book of Business NurseLine Analyses using 2010 claims.
2. NurseLine operational data for pilot client comparing activity data from Q4 2009-Q1 2010 to data for Q4 2010-Q1 2011.
3. UnitedHealthcare Fully Insured pilot, compared 3-month period in 2009 Case Management enrollments from NurseLine referrals over 3-month 2009 period to 3-month period in 2010.
4. Ongoing UnitedHealthcare NurseLine utilization user survey, 2011.
5. Confidential to the fullest extent permitted by law.
6. UnitedHealth Group Book-of-Business Care24 member surveys, 2010.

UnitedHealthcare Insurance Company

UnitedHealthcare

For informational purposes only. NurseLine℠ nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor's care. NurseLine services are not an insurance program and may be discontinued at any time.

The Care24℠ program integrates elements of traditional employee assistance and work-life programs with health information lines for a comprehensive set of resources. It is not a substitute for a doctor's or professional's care. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and are subject to change. Coverage exclusions and limitations may apply.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

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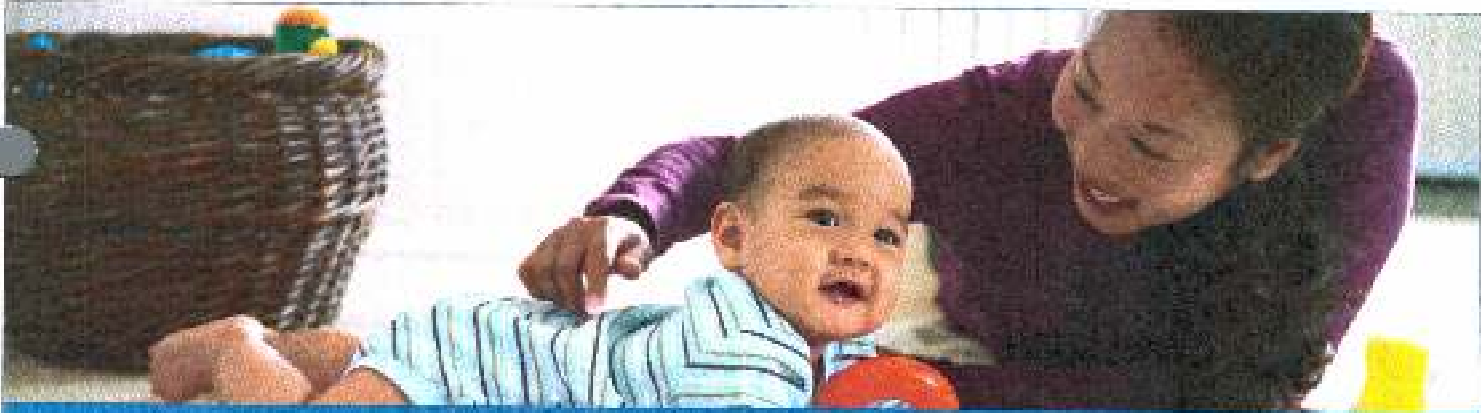

Individual support for healthy babies and moms

Get personalized help through pregnancy and delivery with the Healthy Pregnancy Program.

Special services to help you during a special time in your life.

We want to help ensure you have a smooth pregnancy, delivery and a healthy baby. That's why we created the Healthy Pregnancy Program. By seeing your doctor regularly, and by enrolling in our Healthy Pregnancy Program, which is provided at no additional cost for UnitedHealthcare® plan members, you'll have built-in support through every stage of your pregnancy.

Personal attention

When you enroll in our Healthy Pregnancy Program, a registered nurse will consult with you, via the telephone, to help you determine what, if any, risks or complications could arise during your pregnancy. We can help you learn and practice healthy pregnancy habits and protect the well being of your baby. If you have individual needs, a Healthy Pregnancy Program nurse will provide one-on-one support throughout your pregnancy.

Educational materials and resources

At **www.healthy-pregnancy.com**, you can access a full range of articles covering nutrition, exercise, childbirth preparation, tips for Dads and more. Our website also offers you a Healthy Pregnancy Owners' Manual that will walk you through what to expect before, during and after your pregnancy.

Enroll for these benefits

- Toll-free access to experienced nurses
- Identification of your risks and individual needs
- Pregnancy and childbirth education materials and resources
- Access to Online Healthy Pregnancy Owner's Manual

24-hour help

After you enroll in the program, you can call our maternity nurses 24 hours a day to ask questions or talk over your concerns. Call 1-888-246-7389* toll-free whenever you choose. After delivery, many moms still find they need support or answers to their questions. Experienced nurses who can answer your questions are available to talk by phone, even after your baby is born.

Enroll at your convenience

To get the most from the program, it's best to enroll during the first trimester of your pregnancy. But you can enroll whenever you like, up through the end of your pregnancy.

Complimentary gift for you and your baby

Enroll in the Healthy Pregnancy Program and you'll receive a complimentary gift for you and your baby.

- *Mayo Clinic Guide to a Healthy Pregnancy*, a book that will help you learn more about your nine-month journey and offers support for the decisions regarding your care.

Enroll today

Why wait? Get the most from the personalized attention and educational materials starting today.

You can enroll up through the end of your pregnancy.

To Enroll:

Call 1-888-246-7389* toll-free

Monday – Friday 8 a.m. to 8 p.m. CST

For more information visit:
www.healthy-pregnancy.com

*Please note access for questions and concerns is available 24/7, however program enrollment is limited to specific times.

This program follows national practice standards from the Institute for Clinical Systems Improvement. The Healthy Pregnancy Program cannot diagnose problems or recommend specific treatment. The information provided is not a substitute for your doctor's care.

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Becoming a Dad?

The Healthy Pregnancy program isn't just for moms!

We'll help give you both peace of mind and provide you with resources as you prepare for your new baby.

For many men, becoming a father can be one of the most emotionally intense experiences of their lives.

While a pregnancy brings many changes and challenges – for both the mother- and father-to-be, the experience can also bring you closer together as a family. You may not know how to handle every situation; just being there to listen is one of the best things you can do for your partner. Plus, there are amazing things awaiting you – seeing that first sonogram picture, talking to the baby before he or she is even born, hearing the baby's heartbeat, feeling the baby kick!

Start preparing now to find out what you need to know as you prepare to become a dad. At **www.healthy-pregnancy.com**, you'll find many different articles about what you and your partner can expect before, during and after pregnancy. Plus, your spouse has 24-hour access to experienced nurses all during pregnancy and even after delivery. And, it's all provided at no additional cost for UnitedHealthcare plan members!

Encourage your spouse to enroll in the Healthy Pregnancy Program today.

The Healthy Pregnancy Program helps give both of you extra security and peace of mind, so you can enjoy one of the most beautiful and miraculous experiences in life. Enroll and receive:

- Toll-free, 24-hour access to experienced nurses
- Personalized support to identify risks and individual needs
- Pregnancy and childbirth education materials and resources
- Access to the online Healthy Pregnancy Owner's Manual

For more information, or to enroll

Just call **1-888-246-7389** M–F, 8 a.m. – 8 p.m. Central time

For more information, visit **www.healthy-pregnancy.com**

*Please note: Access for questions and concerns is available 24/7; however, program enrollment is limited to specific times.

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Preventive Care Services to help you manage your health

UnitedHealthcare is dedicated to helping people live healthier lives, and we encourage regular preventive care visits with a network physician to help maintain your health.

UnitedHealthcare encourages you to obtain preventive care services and health screenings, as appropriate for your age, to help maintain or improve your health. Regular preventive care visits and health screenings may help to identify potential health risks for early diagnosis and treatment. The following recommended preventive care guidelines², along with the advice of your doctor, may help you stay healthy and reach your health and wellness goals, helping you live a healthier life.

Under the Affordable Care Act (ACA)¹, most UnitedHealthcare plan members are eligible to receive certain preventive health care services, based upon age, gender and other factors without cost sharing (the amount you pay for some of the costs of your health care). Certain preventive care services are covered at 100% without charging a copayment, coinsurance or deductible, as long as you obtain the services from a health plan network provider. UnitedHealthcare also covers diagnostic (non-preventive) services which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Summary of preventive care guidelines

UnitedHealthcare is committed to advancing prevention and early detection of disease. The following is a high-level summary of the preventive care guideline recommendations.

Preventive care screening services for members at an appropriate age and/or risk status:

- Well examination
- Obesity
- High blood pressure
- Diabetes for certain populations
- Cholesterol (Lipid disorders - with no prior history)
- Human Immunodeficiency Virus (HIV)
- Colorectal cancer for ages 50-75
- Hepatitis C Virus Infection
- Lung Cancer with low-dose CT Scan recommended for ages 55-80 with at least a 30 pack-year smoking history, requires prior authorization.
- All standard immunizations within the ages recommended, if any, by the Federal Drug Administration (FDA) or Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

Primary Care Counseling:

- Interventions to prevent Tobacco use and Tobacco related disease; may include certain smoking cessation medications as prescribed by physician and meeting approved guidelines.
- To promote a healthy diet
- To reduce alcohol misuse
- For depression
- For injury and fall prevention
- For intimate partner violence

Women's preventive care screening services at an appropriate age and/or risk status:

- Well-women visits
- Certain sexually transmitted infections
- Cervical cancer, Pap Smear - for ages 21 to 65 years
- Human papilloma virus (HPV) DNA testing beginning at age 30
- Mammography for all adult women
- Breast Cancer prevention counseling strategies for women at high risk for breast cancer
- Osteoporosis for certain populations
- Folic Acid – Recommended for all women beginning at age 18 who are planning or capable of childbearing
- Breast Cancer Genetic Test Evaluation and Counseling (BRCA), for ages 18+ with a family history of breast or ovarian cancer
- FDA Approved Contraception Methods and Counseling

Having trouble understanding some of the health insurance terms and/or conditions on this flyer? Visit **GlossaryJustPlainClear.com** to see helpful definitions.

Women's preventive health screening:
continued

- Interpersonal and Domestic Violence Screening and Counseling
- **Screenings for Pregnant women:**
  - Gestational Diabetes Screening
  - Screening for Rubella, Iron Deficiency Anemia, Urinary Tract Infection
  - Hepatitis B, Blood Type and RH(D) Incompatibility Screening
  - Primary Care interventions to promote breast feeding and Post Partum Counseling, Equipment and Supplies

Men's preventive care screening services at an appropriate age and/or risk status:

- Abdominal aortic aneurysm for men 65–75 years old who have ever smoked

Children's preventive care screening services at an appropriate age and/or risk status:

Services at each preventive visit will vary based on age, but may include some of the following:

- Age appropriate well examination
- Measurement of your child's head size
- Measurement of length/height and weight
- Metabolic screening panel for newborns – age 0–90 days old
- Screening blood tests, if appropriate
- Provide age appropriate immunizations
- Vision screening for children less than age 5
- Oral health risk assessment
- Fluoride application for ages 0–6 years, under certain circumstances
- Hearing screening
- Autism screening at 18 months and 24 months. May be done earlier or more frequently for young children at defined risk
- Counseling on the harmful effects of smoking and illicit use of drugs (for older children and adolescents)
- Counseling for children and their parents on promoting a healthy diet and exercise
- Screening certain children at high risk for high cholesterol, sexually transmitted diseases, lead poisoning, tuberculosis and more
- Screening for depression
- Evaluate the need for iron supplements

Not all children require all of the services identified above. Following your child's preventive visit the doctor should also provide you with information about your child's growth, development and general health, and answer any questions you may have about your child.

Talk to your doctor

Consult your doctor for your specific preventive care recommendations, as he or she is an important source of information about your health.

For more information on preventive care recommendations, visit our online website at **www.uhcpreventivecare.com.** You can view your age appropriate preventive guidelines and email, download or print your results. You can also sign up for preventive care email reminders.

UnitedHealthcare®

These guidelines are based on the recommendations of the U.S. Preventive Services Task Force (USPSTF), U.S. Department of Health and Human Services and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. They are provided for informational purposes only and do not constitute medical advice. Individuals with symptoms or at high risk for disease may need additional services or more frequent interventions. Discuss with your doctor how these guidelines may be right for you and always consult your doctor before making any decisions about medical care. These guidelines do not necessarily reflect the services, screenings or tests that will be covered by your benefit plan. Always refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on your health plan ID card.

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