

Solicitation 2014-301

INSURANCE, MEDICAL STOP LOSS

Bid designation: Public



Collin County

Bid 2014-301 INSURANCE, MEDICAL STOP LOSS

Bid Number **2014-301**
 Bid Title **INSURANCE, MEDICAL STOP LOSS**

Bid Start Date **In Held**
 Bid End Date **Sep 11, 2014 2:00:00 PM CDT**
 Question & Answer End Date **Sep 4, 2014 2:00:00 PM CDT**

Bid Contact **Geri Osinaike, CPPO, CPPB**
Senior Buyer
Purchasing
972-548-4107
gosinaike@co.collin.tx.us

Contract Duration **1 year**
 Contract Renewal **Not Applicable**
 Prices Good for **90 days**

Standard Disclaimer *****Note to Bidders/Offerors~The following standard disclaimer applies to Invitation to Bid (IFB), Competitive Sealed Proposal (CSP), and Request for Proposal (RFP) ONLY, not applicable to Request for Qualifications (RFQ) or Request for Information (RFI).*****
Mailing Address:
Collin County Purchasing
2300 Bloomdale Rd., Ste 3160
McKinney, TX 75071
 Prices bid/proposed shall only be considered if they are provided in the appropriate space(s) on the Collin County bid form(s). For consideration, any additions or deductions to the bid/proposal prices offered must be shown under the exceptions section of the bid/proposal in the case of electronic submittal, ONLY in the case of a hard copy submittal will an additional attachment be allowed. Extraneous numbers, prices, comments, etc. or bidder/offeror generated documents appearing elsewhere on the bid or as an additional attachment shall be deemed to have no effect on the prices offered in the designated locations.
 All delivery and freight charges (F.O.B. inside delivery at Collin County designated locations) are to be included as part of the bid/quote/proposal price. All components required to render the item complete, installed and operational shall be included in the total bid/quote/proposal price. Collin County will pay no additional freight/delivery/installation/setup fees.

Bid Comments Collin County is requesting vendors to propose medical stop loss insurance, which will provide coverage to all members covered by Collin County's self-funded health plan. Collin County desires to partner with vendors who demonstrate a commitment to helping Collin County meet our objectives.

Item Response Form

Item **2014-301--01-01 - Stop Loss Fees : Option #1, \$100,000 12/12**

	Rate Per Employee Per Month
Option #1, \$100,000 12/12	

Delivery Location **Collin County**
Collin County- See P.O.
 See P.O. for Delivery Location
 2300 Bloomdale Rd.
 Ste. 3160
 McKinney TX 75071
 Qty 1

Description

Option #1, \$100,000 12/12

Please provide a do not exceed rate for each of the options listed above. Any increase to the rates provided may not exceed the do not

exceed rate. A rate increase may not be accepted by Collin County unless the offeror can demonstrate a direct correlation to the claims information provided by Collin County.

Item **2014-301--01-02 - Stop Loss Fees : Option #2, \$100,000 12/15**

	Rate Per Employee Per Month
Option #2, \$100,000 12/15	

Delivery Location

Collin County

Collin County- See P.O.
See P.O. for Delivery Location
2300 Bloomdale Rd.
Ste. 3160
McKinney TX 75071
Qty 1

Description

Option #2, \$100,000 12/15

Please provide a do not exceed rate for each of the options listed above. Any increase to the rates provided may not exceed the do not exceed rate. A rate increase may not be accepted by Collin County unless the offeror can demonstrate a direct correlation to the claims information provided by Collin County.

Item **2014-301--01-03 - Stop Loss Fees : Option #3, \$150,000 12/12**

	Rate Per Employee Per Month
Option #3, \$150,000 12/12	

Delivery Location

Collin County

Collin County- See P.O.
See P.O. for Delivery Location
2300 Bloomdale Rd.
Ste. 3160
McKinney TX 75071
Qty 1

Description

Option #3, \$150,000 12/12

Please provide a do not exceed rate for each of the options listed above. Any increase to the rates provided may not exceed the do not exceed rate. A rate increase may not be accepted by Collin County unless the offeror can demonstrate a direct correlation to the claims information provided by Collin County.

Item **2014-301--01-04 - Stop Loss Fees : Option #4, \$150,000 12/15**

	Rate Per Employee Per Month
Option #4, \$150,000 12/15	

Delivery Location

Collin County

Collin County- See P.O.
See P.O. for Delivery Location
2300 Bloomdale Rd.
Ste. 3160
McKinney TX 75071
Qty 1

Description

Option #4, \$150,000 12/15

Please provide a do not exceed rate for each of the options listed above. Any increase to the rates provided may not exceed the do not exceed rate. A rate increase may not be accepted by Collin County unless the offeror can demonstrate a direct correlation to the claims information provided by Collin County.

Item **2014-301--01-05 - Stop Loss Fees : Option #5 \$200,000, 12/12**

	Rate Per Employee Per Month
Option #5 \$200,000, 12/12	

Delivery Location

Collin County

Collin County- See P.O.
 See P.O. for Delivery Location
 2300 Bloomdale Rd.
 Ste. 3160
 McKinney TX 75071
Qty 1

Description

Option #5 \$200,000, 12/12

Please provide a do not exceed rate for each of the options listed above. Any increase to the rates provided may not exceed the do not exceed rate. A rate increase may not be accepted by Collin County unless the offeror can demonstrate a direct correlation to the claims information provided by Collin County.

Item **2014-301--01-06 - Stop Loss Fees : Option #6 \$200,000, 12/15**

	Rate Per Employee Per Month
Option #6 \$200,000, 12/15	

Delivery Location **Collin County**

Collin County- See P.O.
 See P.O. for Delivery Location
 2300 Bloomdale Rd.
 Ste. 3160
 McKinney TX 75071
Qty 1

Description

Option #6 \$200,000, 12/15

Please provide a do not exceed rate for each of the options listed above. Any increase to the rates provided may not exceed the do not exceed rate. A rate increase may not be accepted by Collin County unless the offeror can demonstrate a direct correlation to the claims information provided by Collin County.



COLLIN COUNTY, TEXAS TERMS AND CONDITIONS

1.0 GENERAL INSTRUCTIONS

1.0.1 Definitions

1.0.1.1 Bidder/Quoter/Offeror: refers to submitter.

1.0.1.2 Vendor/Contractor/Provider: refers to a Successful Bidder/Quoter/Contractor/Service Provider.

1.0.1.3 Submittal: refers to those documents required to be submitted to Collin County, by a Bidder/Quoter/Offeror.

1.0.1.4 IFB: refers to Invitation For Bid.

1.0.1.5 RFQ: refers to Request For Qualifications

1.0.1.6 RFP: refers to Request For Proposal.

1.0.1.7 RFI: refers to Request For Information.

1.0.1.8 CSP: refers to Competitive Sealed Proposal

1.0.1.9 Quotation: refers to Request for Quotation

1.1 If Bidder/Quoter/Offeror do not wish to submit an offer at this time, please submit a No Bid Form.

1.2 Awards shall be made not more than ninety (90) days after the time set for opening of submittals.

1.3 Collin County is always conscious and extremely appreciative of your time and effort in preparing your submittal.

1.4 Collin County exclusively uses BidSync for the notification and dissemination of all solicitations. The receipt of solicitations through any other company may result in your receipt of incomplete specifications and/or addendums which could ultimately render your bid non-compliant. Collin County accepts no responsibility for the receipt and/or notification of solicitations through any other company.

1.5 A bid/quote/submittal may not be withdrawn or canceled by the bidder/quoter/offeror prior to the ninety-first (91st) day following public opening of submittals and only prior to award.

1.6 It is understood that Collin County, Texas reserves the right to accept or reject any and/or all Bids/Quotes/Proposals/Submittals for any or all products and/or services covered in an Invitation For Bid (IFB), Request For Qualifications (RFQ), Request For Proposal (RFP), Request For Information (RFI), Competitive Sealed Proposal (CSP), and Quotation, and to waive informalities or defects in submittals or to accept such submittals as it shall deem to be in the best interest of Collin County.

1.7 All IFBs, RFPs, CSPs, RFQs, and RFIs submitted in hard copy paper form shall be submitted in a sealed envelope, plainly marked on the outside with the IFB/RFP/RFQ/RFI/CSP/Quotation number and name. A hard copy paper form submittal shall be manually signed in ink by a person having the authority to bind the firm in a contract. Submittals shall be mailed or hand delivered to the Collin County Purchasing Department.

1.8 No oral, telegraphic or telephonic submittals will be accepted. IFBs, RFPs, RFQs, CSPs, and RFIs, may be submitted in electronic format via **BidSync**.

1.9 All Invitation For Bids (IFB), Request For Proposals (RFP), Request For Qualifications (RFQ), Competitive Sealed Proposals (CSP), and Request For Information (RFI), submitted electronically via **BidSync** shall remain locked until official date and time of opening as stated in the Special Terms and Conditions of the IFB, RFP, RFQ, CSP, and/or RFI.

1.10 Time/date stamp clock in Collin County Purchasing Department shall be the official time of receipt for all Invitation For Bids (IFB), Request For Proposals (RFP), Request For Qualifications (RFQ), Competitive Sealed Proposals (CSP), Request For Information (RFI), submitted in hard copy paper form. IFBs, RFPs, RFQs, CSPs, RFIs, received in County Purchasing Department after submission deadline shall be considered void and unacceptable. Absolutely no late submittals will be considered. Collin County accepts no responsibility for technical difficulties related to electronic submittals.

1.11 For hard copy paper form submittals, any alterations made prior to opening date and time must be initialed by the signer of the IFB/RFQ/RFP/CSP/RFI, guaranteeing authenticity. Submittals cannot be altered or amended after submission deadline.

1.12 Collin County is by statute exempt from the State Sales Tax and Federal Excise Tax; therefore, the prices submitted shall not include taxes.

1.13 Any interpretations, corrections and/or changes to an Invitation For Bid/Request For Qualifications/Request For Proposal/Request for Information/Competitive Sealed Proposal, and related Specifications or extensions to the opening/receipt date will be made by addenda to the respective document by the Collin County Purchasing Department. Questions and/or clarification requests must be submitted no later than seven (7) days prior to the opening/receipt date. Those received at a later date may not be addressed prior to the public opening. Sole authority to authorize addenda shall be vested in Collin County Purchasing Agent as entrusted by the Collin County Commissioners' Court. Addenda may be transmitted electronically via **BidSync**, by facsimile, E-mail transmission or mailed via the US Postal Service.

1.13.1 Addenda will be transmitted to all that are known to have received a copy of the IFB/RFQ/RFP/RFI/CSP and related Specifications. However, it shall be the sole responsibility of the Bidder/Quoter/Offeror to verify issuance/non-issuance of addenda and to check all avenues of document availability (i.e. **BidSync at www.bidsync.com**, telephoning Purchasing Department directly, etc.) prior to opening/receipt date and time to insure Bidder/Quoter/Offeror's receipt of any addenda issued. Bidder/Quoter/Offeror shall acknowledge receipt of all addenda.

1.14 All materials and services shall be subject to Collin County approval.

1.15 Collin County reserves the right to make award in whole or in part as it deems to be in the best interest of the County.

1.16 The Bidder/Quoter/Offeror shall comply with Commissioners' Court Order No. 96-680-10-28, Establishment of Guidelines & Restrictions Regarding the Acceptance of Gifts by County Officials & County Employees.

1.17 Any reference to model/make and/or manufacturer used in specifications is for descriptive

purposes only. Products/materials of like quality will be considered.

1.18 Bidders/Quoters/Offerors taking exception to the specifications shall do so at their own risk. By offering substitutions, Bidder/Quoter/Offeror shall state these exceptions in the section provided in the IFB/RFQ/RFP/CSP/Quotation or by attachment. Exception/substitution, if accepted, must meet or exceed specifications stated therein. Collin County reserves the right to accept or reject any and/or all of the exception(s)/substitution(s) deemed to be in the best interest of the County.

1.19 Minimum Standards for Responsible Prospective Bidders/Quoters/Offerors: A prospective Bidder/Quoter/Offeror must meet the following minimum requirements:

1.19.1 have adequate financial resources, or the ability to obtain such resources as required;

1.19.2 be able to comply with the required or proposed delivery/completion schedule;

1.19.3 have a satisfactory record of performance;

1.19.4 have a satisfactory record of integrity and ethics;

1.19.5 be otherwise qualified and eligible to receive an award.

Collin County may request documentation and other information sufficient to determine Bidder's/Quoter's/Offeror's ability to meet these minimum standards listed above.

1.20 Vendor shall bear any/all costs associated with its preparation of an RFI/IFB/RFQ/RFP/CSP/Quotation submittal.

1.21 Public Information Act: Collin County is governed by the Texas Public Information Act, Chapter 552 of the Texas Government Code. All information submitted by prospective bidders during the bidding process is subject to release under the Act.

1.22 The Bidder/Quoter/Offeror shall comply with Commissioners' Court Order No. 2004-167-03-11, County Logo Policy.

1.23 Interlocal Agreement: Successful bidder agrees to extend prices and terms to all entities that has entered into or will enter into joint purchasing interlocal cooperation agreements with Collin County.

1.24 Bid Openings: All bids submitted will be read at the county's regularly scheduled bid opening for the designated project. However, the reading of a bid at bid opening should be not construed as a comment on the responsiveness of such bid or as any indication that the county accepts such bid as responsive.

The county will make a determination as to the responsiveness of bids submitted based upon compliance with all applicable laws, Collin County Purchasing Guidelines, and project documents, including but not limited to the project specifications and contract documents. The county will notify the successful bidder upon award of the contract and, according to state law; all bids received will be available for inspection at that time.

2.0 TERMS OF CONTRACT

2.1 A bid/quote/proposal, when properly accepted by Collin County, shall constitute a contract equally binding between the Vendor/Contractor/Provider and Collin County. No different or additional terms will become part of this contract with the exception of an Amendment and/or a Change Order.

2.2 No oral statement of any person shall modify or otherwise change, or affect the terms, conditions or specifications stated in the resulting contract. All Amendments and/or Change Orders to the contract will be made in writing by Collin County Purchasing Agent.

2.3 No public official shall have interest in the contract, in accordance with Vernon's Texas Codes Annotated, Local Government Code Title 5, Subtitle C, Chapter 171.

2.4 The Vendor/Contractor/Provider shall comply with Commissioners' Court Order No. 96-680-10-28, Establishment of Guidelines & Restrictions Regarding the Acceptance of Gifts by County Officials & County Employees.

2.5 Design, strength, quality of materials and workmanship must conform to the highest standards of manufacturing and engineering practice.

2.6 Bids/Quotes/Proposals must comply with all federal, state, county and local laws concerning the type(s) of product(s)/service(s)/equipment/project(s) contracted for, and the fulfillment of all ADA (Americans with Disabilities Act) requirements.

2.7 All products must be new and unused, unless otherwise specified, in first-class condition and of current manufacture. Obsolete products, including products or any parts not compatible with existing hardware/software configurations will not be accepted.

2.8 Vendor/Contractor/Provider shall provide any and all notices as may be required under the Drug-Free Work Place Act of 1988, 28 CFR Part 67, Subpart F, to its employees and all sub-contractors to insure that Collin County maintains a drug-free work place.

2.9 Vendor/Contractor/Provider shall defend, indemnify and save harmless Collin County and all its officers, agents and employees and all entities, their officers, agents and employees who are participating in this contract from all suits, claims, actions, damages (including personal injury and or property damages), or demands of any character, name and description, (including attorneys' fees, expenses and other defense costs of any nature) brought for or on account of any injuries or damages received or sustained by any person, persons, or property on account of Vendor/Contractor/Provider's breach of the contract arising from an award, and/or any negligent act, error, omission or fault of the Vendor/Contractor/Provider, or of any agent, employee, subcontractor or supplier of Vendor/Contractor/Provider in the execution of, or performance under, any contract which may result from an award. Vendor/Contractor/Provider shall pay in full any judgment with costs, including attorneys' fees and expenses which are rendered against Collin County and/or participating entities arising out of such breach, act, error, omission and/or fault.

2.10 If a contract, resulting from a Collin County IFB, RFP, RFQ, CSP, Quotation is for the execution of a public work, the following shall apply:

2.10.1 In accordance with V.T.C.A. 2253.021, a governmental agency that makes a public work contract with a prime contractor shall require the contractor, before beginning work, to execute to the governmental entity a Payment Bond if the contract is in excess of \$25,000.00. Such bond shall be in the amount of the contract payable to the governmental entity and must be executed by a corporate surety in accordance with Section 1, Chapter 87, Acts of the 56th Legislature, Regular Session, 1959 (Article 7.19-1 Vernon's Texas Insurance Code).

2.10.2 In accordance with V.T.C.A. 2253.021, a governmental agency that makes a public work contract with a prime contractor shall require the contractor, before beginning work, to execute to the governmental entity a Performance Bond if the contract is in excess of \$100,000.00. Such bond shall be in the amount of the contract payable to the governmental entity and must be executed by a corporate surety in accordance with Section 1, Chapter 87, Acts of the 56th Legislature, Regular Session, 1959 (Article 7.19-1 Vernon's Texas Insurance Code).

2.11 Purchase Order(s) shall be generated by Collin County to the vendor. Collin County will not be responsible for any orders placed/delivered without a valid purchase order number.

2.12 The contract shall remain in effect until any of the following occurs: delivery of product(s) and/or completion and acceptance by Collin County of product(s) and/or service(s), contract expires or is terminated by either party with thirty (30) days written notice prior to cancellation and notice must state therein the reasons for such cancellation. Collin County reserves the right to terminate the contract immediately in the event the Vendor/Contractor/Provider fails to meet delivery or completion schedules, or otherwise perform in accordance with the specifications. Breach of contract or default authorizes the County to purchase elsewhere and charge the full increase in cost and handling to the defaulting Vendor/Contractor/Provider.

- 2.13 Collin County Purchasing Department shall serve as Contract Administrator or shall supervise agents designated by Collin County.
- 2.14 All delivery and freight charges (FOB Inside delivery at Collin County designated locations) are to be included as part of the bid/quote/proposal price. All components required to render the item complete, installed and operational shall be included in the total bid/quote/proposal price. Collin County will pay no additional freight/delivery/installation/setup fees.
- 2.15 Vendor/Contractor/Provider shall notify the Purchasing Department immediately if delivery/completion schedule cannot be met. If delay is foreseen, the Vendor/Contractor/Provider shall give written notice to the Purchasing Agent. The County has the right to extend delivery/completion time if reason appears valid.
- 2.16 The title and risk of loss of the product(s) shall not pass to Collin County until Collin County actually receives and takes possession of the product(s) at the point or points of delivery. Collin County shall generate a purchase order(s) to the Vendor/Contractor/Provider and the purchase order number must appear on all itemized invoices.
- 2.17 Invoices shall be mailed directly to the Collin County Auditor's Office, 2300 Bloomdale Road, Suite 3100, McKinney, Texas 75071. All invoices shall show:
- 2.17.1 Collin County Purchase Order Number;
 - 2.17.2 Vendor's/Contractor's/Provider's Name, Address and Tax Identification Number;
 - 2.17.3 Detailed breakdown of all charges for the product(s) and/or service(s) including applicable time frames.
- 2.18 Payment will be made in accordance with V.T.C.A., Government Code, Title 10, Subtitle F, Chapter 2251.
- 2.19 All warranties shall be stated as required in the Uniform Commercial Code.
- 2.20 The Vendor/Contractor/Provider and Collin County agree that both parties have all rights, duties, and remedies available as stated in the Uniform Commercial Code.
- 2.21 The Vendor/Contractor/Provider agree to protect Collin County from any claims involving infringements of patents and/or copyrights.
- 2.22 The contract will be governed by the laws of the State of Texas. Should any portion of the contract be in conflict with the laws of the State of Texas, the State laws shall invalidate only that portion. The remaining portion of the contract shall remain in effect. The contract is performable in Collin County, Texas.
- 2.23 The Vendor/Contractor/Provider shall not sell, assign, transfer or convey the contract, in whole or in part, without the prior written approval from Collin County.
- 2.24 The apparent silence of any part of the specification as to any detail or to the apparent omission from it of a detailed description concerning any point, shall be regarded as meaning that only the best commercial practices are to prevail. All interpretations of the specification shall be made on the basis of this statement.
- 2.25 Vendor/Contractor/Provider shall not fraudulently advertise, publish or otherwise make reference to the existence of a contract between Collin County and Vendor/Contractor/Provider for purposes of solicitation. As exception, Vendor/Contractor/Provider may refer to Collin County as an evaluating reference for purposes of establishing a contract with other entities.
- 2.26 The Vendor/Contractor/Provider understands, acknowledges and agrees that if the Vendor/Contractor/Provider subcontracts with a third party for services and/or material, the primary Vendor/Contractor/Provider (awardee) accepts responsibility for full and prompt payment to the third party. Any dispute between the primary Vendor/Contractor/Provider and the third party, including any payment dispute, will

be promptly remedied by the primary vendor. Failure to promptly render a remedy or to make prompt payment to the third party (subcontractor) may result in the withholding of funds from the primary Vendor/Contractor/Provider by Collin County for any payments owed to the third party.

2.27 Vendor/Contractor/Provider shall provide Collin County with diagnostic access tools at no additional cost to Collin County, for all Electrical and Mechanical systems, components, etc., procured through this contract.

2.28 Criminal History Background Check: If required, ALL individuals may be subject to a criminal history background check performed by the Collin County's Sheriff's Office prior to access being granted to Collin County. Upon request, Vendor/Contractor/Provider shall provide list of individuals to Collin County Purchasing Department within five (5) working days.

2.29 Non-Disclosure Agreement: Where applicable, vendor shall be required to sign a non-disclosure agreement acknowledging that all information to be furnished is in all respects confidential in nature, other than information which is in the public domain through other means and that any disclosure or use of same by vendor, except as provided in the contract/agreement, may cause serious harm or damage to Collin County. Therefore, Vendor agrees that Vendor will not use the information furnished for any purpose other than that stated in contract/agreement, and agrees that Vendor will not either directly or indirectly by agent, employee, or representative disclose this information, either in whole or in part, to any third party, except on a need to know basis for the purpose of evaluating any possible transaction. This agreement shall be binding upon Collin County and Vendor, and upon the directors, officers, employees and agents of each.

2.30 Vendors/Contractors/Providers must be in compliance with the Immigration and Reform Act of 1986 and all employees specific to this solicitation must be legally eligible to work in the United States of America.

2.31 Certification of Eligibility: This provision applies if the anticipated Contract exceeds \$100,000.00 and as it relates to the expenditure of federal grant funds. By submitting a bid or proposal in response to this solicitation, the Bidder/Quoter/Offeror certifies that at the time of submission, he/she is not on the Federal Government's list of suspended, ineligible, or debarred contractors. In the event of placement on the list between the time of bid/proposal submission and time of award, the Bidder/Quoter/Offeror will notify the Collin County Purchasing Agent. Failure to do so may result in terminating this contract for default.

2.32 Notice to Vendors/Contractors/Providers delivering goods or performing services within the Collin County Detention Facility: The Collin County Detention Facility houses persons who have been charged with and/or convicted of serious criminal offenses. When entering the Detention Facility, you could: (1) hear obscene or graphic language; (2) view partially clothed male inmates; (3) be subjected to verbal abuse or taunting; (4) risk physical altercations or physical contact, which could be minimal or possibly serious; (5) be exposed to communicable or infectious diseases; (6) be temporarily detained or prevented from immediately leaving the Detention Facility in the case of an emergency or "lockdown"; and (7) subjected to a search of your person or property. While the Collin County Sheriff's Office takes every reasonable precaution to protect the safety of visitors to the Detention Facility, because of the inherently dangerous nature of a Detention Facility and the type of the persons incarcerated therein, please be advised of the possibility of such situations exist and you should carefully consider such risks when entering the Detention Facility. By entering the Collin County Detention Facility, you acknowledge that you are aware of such potential risks and willingly and knowingly choose to enter the Collin County Detention Facility.

2.33 Delays and Extensions of Time when applicable:

2.33.1 If the Vendor/Contractor/Provider is delayed at any time in the commence or progress of the Work by an act or neglect of the Owner or Architect/Engineer, or of an employee of either, or of a separate contractor employed by the Owner, or by changes ordered in the Work, or by labor disputes, fire, unusual delay in deliveries, unavoidable casualties or other causes beyond the Vendor/Contractor/Provider's control, or by delay authorized by the Owner pending mediation and arbitration, or by other causes which the Owner or Architect/Engineer determines may justify delay, then the Contract Time shall be extended by Change Order for such reasonable time as the Owner/Architect may determine.

2.33.2 If adverse weather conditions are the basis for a Claim for additional time, such Claim shall be documented by data substantiating that weather conditions were abnormal for the period of time and could not

have been reasonably anticipated, and that the weather conditions had an adverse effect on the scheduled construction.

NOTE: All other terms and conditions (i.e. Insurance Requirements, Bond Requirements, etc.) shall be stated in the individual IFB/RFQ/RFP/RFI/CSP/Quotation Solicitation documents as Special Terms, Conditions and Specifications.

3.0 INSURANCE REQUIREMENTS

3.1 Before commencing work, the vendor shall be required, at its own expense, to furnish the Collin County Purchasing Agent with certified copies of all insurance certificate(s) indicating the coverage to remain in force throughout the term of this contract.

3.1.1 **Commercial General Liability** insurance including but not limited to the coverage indicated below. Coverage shall not exclude or limit Products/Completed Operations, Contractual Liability, or Cross Liability.

- Each Occurrence: \$1,000,000
- Personal & Adv Injury: \$1,000,000
- Products/Completed Operation: \$1,000,000
- General Aggregate: \$2,000,000

3.1.2 **Workers Compensation** insurance as required by the laws of Texas, and Employers' Liability.

Employers' Liability

- Liability, Each Accident: \$500,000
- Disease-Each Employee: \$500,000
- Disease – Policy Limit: \$500,000

3.1.3 **Commercial Automobile Liability** insurance including owned, non-owned, and hired vehicles used in connection with the contract.

- Combined Single Limit – Each Accident: \$1,000,000

3.1.4 **Professional/Errors & Omissions Liability** insurance with a two (2) year extended period of coverage, (i.e. tail coverage). If you choose to have project coverage endorsed onto your base policy, this would be acceptable.

- Each Occurrence/Aggregate: \$5,000,000

3.2 With reference to the foregoing insurance requirement, the vendor shall endorse applicable insurance policies as follows:

3.3.1 A waiver of subrogation in favor of Collin County, its officials, employees, volunteers and officers shall be contained in all policies.

3.3.2 The vendor's insurance coverage shall name Collin County as additional insured under the General Liability policy.

3.3.3 All insurance policies shall be endorsed to require the insurer to immediately notify Collin County of any decrease in the insurance coverage limits.

3.3.4 All insurance policies shall be endorsed to the effect that Collin County will receive at least thirty (30) days notice prior to cancellation, non-renewal or termination of the policy.

3.3.5 All copies of Certificates of Insurance shall reference the project/contract number.

3.4 All insurance shall be purchased from an insurance company that meets the following requirements:

3.4.1 A financial rating of B+VI or better as assigned by the BEST Rating Company or equivalent.

3.5 Certificates of Insurance shall be prepared and executed by the insurance company or its authorized agent, and shall contain provisions representing and warranting the following:

3.5.1 Sets forth all endorsements and insurance coverages according to requirements and instructions contained herein.

3.5.2 Sets forth the notice of cancellation or termination to Collin County.

4.0 GENERAL INFORMATION & SPECIFICATIONS

4.1 INTRODUCTION

Collin County is requesting vendors to propose medical stop loss insurance, which will provide coverage to all members covered by Collin County's self-funded health plan. Collin County desires to partner with vendors who demonstrate a commitment to helping Collin County meet our objectives.

Collin County is a political subdivision of the State of Texas with positions in areas such as law enforcement, clerical, service/maintenance, skilled crafts, professional, technical and para-professional.

Collin County has been self-funded for over 12 years. The medical plan year is January 1st through December 31st. UnitedHealthcare is the current administrator of our medical plan. We do not provide for out of network benefits except for lasik, emergency room care, vision and mental health benefits. Collin County is committed to self-funding and keeping our benefit program financially sound.

Our current stop loss coverage is a \$100,000 specific. In 2015, Collin County's contract will be a 12/12 beginning January 1st and ending December 31st. There is no aggregate coverage currently in place. UnitedHealthcare is the current administrator for our medical stop loss coverage.

There are 1391 total participants, 1375 are employees, 11 are retirees and 5 are COBRA participants enrolled in the medical insurance as of April 30, 2014. Coverage is broken down into the following categories:

- Participant only: 536
- Participant and child: 249
- Participant and spouse: 223
- Participant and family: 383

These participants insure another 1,808 individuals as either a spouse or dependent child. Collin County offers eligible employees and retirees the option to enroll in the Advantage (basic) or the Advantage Plus (premium) medical plans. Both plans cover the majority of the same services but have different co-payments, co-insurance amounts, deductibles and out-of-pocket maximums. For retirees over the age of 65, Medicare is considered primary and Collin County is secondary.

Collin County has implemented various cost control methods over the last few years such as; separating retiree claims from employee claims in order to determine actuarial premium rates for retirees, removing out-of-network coverage, increasing emergency room copays, utilizing an on-site nurse liaison and offering wellness premium discounts and/or lump sum payments to participants that complete specified wellness requirements.

The following documents are attached for the offerors review:

1. 2012 Dual Plan Summary – Attachment A
2. 2013 Dual Plan Summary – Attachment B
3. 2014 Dual Plan Summary – Attachment C
4. 2012 Medical Plan Employee Premiums – Attachment D
5. 2013 Medical Plan Employee Premiums – Attachment E
6. 2014 Medical Plan Employee Premiums – Attachment F
7. Policy Data- Advantage Plan – Attachment G
8. Policy Data- Advantage Plus Plan – Attachment H
9. Retiree and COBRA Medical Census – Attachment I
10. Active Employee Medical Census – Attachment J
11. 2012 Large Claim Loss with Diagnosis – Attachment K
12. 2013 Large Claim Loss with Diagnosis – Attachment L
13. 2014 Large Claim Loss with Diagnosis – Attachment M

4.2 CONDITIONS

4.2.1 Contract Term: The County will enter into an agreement beginning January 1, 2015, through December 31, 2015.

4.2.2 Funding: Funds for payment have been provided through the Collin County budget approved by the Commissioners' Court for this fiscal year only. The State of Texas statutes prohibits the County from any obligation of public funds beyond the fiscal year for which a budget has been approved. Therefore, anticipated orders or other obligations that arise past the end of the current Collin County fiscal year shall be subject to budget approval.

4.2.3 Price Considerations: If during the life of the contract, the vendor's net prices to other customers under the same terms and conditions for items/services awarded herein are reduced below the contracted price, it is understood and agreed that the benefits of such reduction shall be extended to Collin County.

4.2.4 Changes in Services Provided: Collin County reserves the right to add or reduce any and all services provided. If such an addition or reduction occurs, the offeror agrees that this change will not negatively affect the prices of any of the remaining services provided.

4.2.5 Termination: Collin County reserves the right to cancel the contract at any time for any reason. If the contract is cancelled by Collin County, services will terminate after a 30 day termination notice has been provided by Collin County.

4.2.6 Negotiations: Discussions may be conducted with responsible offerors who submit proposals determined to be possibly selected for award. Offerors will be accorded fair and equal treatment with respect to an opportunity for discussion and revision of proposals. Revisions to proposals may be permitted after submission and before award for the purpose of obtaining best

and final offers.

Offerors may be required to submit additional data during the process of any negotiations.

Collin County reserves the right to negotiate the price and any other term with the offerors.

Any oral negotiations shall be confirmed in writing prior to award.

4.2.7 Rejection of Proposals: Collin County may:

waive any defect, irregularity or informality in any proposal;

reject any proposal or any parts of any proposal;

accept proposals from one or more offerors;

or procure the services in whole or in part by other means.

4.2.8 Proposal Guidelines: Under no circumstances should any employee of Collin County or any public official other than those indicated in this RFP, be contacted between the initial receipt of the RFP and the awarding of the contract. Failure to follow this requirement may result in an automatic disqualification of proposal. Current carriers, in conducting current business, may not reference the RFP to any County employee or official other than those indicated in this RFP.

4.2.8.1 Any coverage or service that cannot provide but is requested in this Request for Proposal, shall be disclosed in writing in 5.3 Deviations at the end of the proposal. If no deviations are listed it is understood that the offeror has agreed to all requests as listed in the RFP. The offeror will be held strictly responsible for all items contained in the specific requirements. The RFP supersede any final contract requirement if there is a variance between the two.

4.2.8.2 Offerors submitting proposals are expected to comply with federal, state, and local laws and regulations applicable to the plan design, services, and payments for services which are being proposed. Proposals submitted will be presumed to be in compliance with all applicable laws.

4.2.8.3 Do not include commissions or overrides in your quoted rates and fees. No commissions will be paid by Collin County to any individual or organization. Disclose the amount of any fees that are being paid.

4.2.8.4 Each provider may only submit one (1) proposal. Collin County will not accept multiple proposals from a provider (i.e. ABC Company and DEF Company cannot both submit a GHI Company proposal). If multiple proposals are submitted, the proposal that is received first will be the proposal that is considered.

4.2.8.5 A broker or consultant may provide multiple proposals from different insurance companies. However, each insurance company's proposal must be provided in its own

paper or digital format separate from any other proposals that the broker or consultant may provide and must include the references and all required data for each insurance company.

4.2.8.6 The offeror shall indemnify, hold, and save the County, their agents, officers and employees harmless from liability of any nature or kind, including costs, expenses, and attorney's fees, for harm suffered by an entity or person as a result of the negligent, reckless, or willful acts of omissions by the carrier, its officers, agents or employees.

4.2.8.7 The offeror shall state any and all costs outside of the monthly administration fees such as one time startup costs in 5.2.4 Financial Information.

4.2.8.8 The contract shall reflect the intent of this RFP. Even if the contract does not address an issue covered by the RFP, terms and commitments agreed to in the RFP will be applicable.

4.3 SUBMISSION REQUIREMENTS

4.3.1 Submission of Proposal: To be considered, proposals shall be received by 2:00 p.m., **September 11, 2014**, in the Purchasing Department or via www.bidsync.com.

All proposals shall be addressed to:

Collin County Purchasing Department
Attn: Geri Osinaike,
Collin County Administration Building
2300 Bloomdale, Suite 3160
McKinney, Texas 75071

The envelope in which the proposal is enclosed must be marked:

SEALED PROPOSAL
INSURANCE, MEDICAL STOP LOSS
RFP NO. **2014-301**

To achieve a uniform review process and to obtain a maximum degree of comparability, vendors may submit proposals via www.bidsync.com or if vendor chooses to submit manually Collin County requires that proposals be submitted with a master (marked original) and three (3) copies.

NOTE: If submitting manually, offeror shall submit, in addition to the hard copies, a CD copy. Microsoft Word format is preferred.

POINT OF CONTACT: Information regarding the purchasing process and the contents of this RFP may be obtained from the Collin County Purchasing Department, Attn: Geri Osinaike

4.3.2 Clarification or objection to proposal specification: If any offeror contemplating submitting a proposal for this contract is in doubt as to the true meaning of the specifications or other documents or any part thereof, they may submit questions to the Purchasing Department on or before FIVE DAYS PRIOR to the date the bids are due. All such requests for information shall be made in writing and the offeror submitting the request will be responsible for its prompt delivery. Any interpretation of the RFP will be made only by RFP Addendum duly issued. A copy of such RFP Addendum will be posted at www.bidsync.com.

4.3.3 Incurred Expenses: There is no expressed or implied obligation for Collin County to reimburse offerors for any expense incurred in preparing proposals in response to this request, and Collin County will not reimburse anyone for these expenses. Collin County will consider proposals from all responsible offerors.

4.3.4 Schedule of Events

RFP released:	August 26, 2014
Deadline for submission of vendor questions:	September 4, 2014
Proposals due:	September 11, 2014 2:00 p.m.
Vendor(s) selected contract approved:	October 20, 2014
Effective date of contract:	January 1, 2015

Collin County reserves the right to change the schedule of events as it deems necessary.

4.3.5 Required Documents: The following documentation must be submitted with the proposal. Please note that this section may not list all of the documentation that is required by the RFP. The offeror is cautioned to read the entire RFP to determine all requirements.

COLLIN COUNTY RESERVES THE RIGHT TO REJECT A PROPOSAL THAT DOES NOT CONTAIN ALL INFORMATION REQUIRED BY THIS RFP.

All proposals are to include the following:

4.3.5.1 Title Page

Title page must show the RFP subject; the offeror's name; the name, address, email and telephone number of a contact person; and the date of the proposal.

4.3.5.2 Transmittal Letter

A signed letter must briefly address the offeror's understanding of the medical stop loss services being requested, the commitment to provide the services required and a statement explaining why the offeror believes itself to be best qualified to provide the services detailed within this RFP.

4.3.5.3 Financial Information

Please submit the following financial documents with your proposal:

- Copies of your last two (2) audited financials including balance sheets and income statements.
- Plans for merger/divestiture or a major capital investment or divestment or major claims administration conversion during the next twelve (12) months.
- S/P, AM Best, and Weiss Ratings

4.3.5.4 Detailed Proposal

The detailed proposal must address the ability to provide services for each requirement as set forth in the RFP. Any options or alternatives to the requirements should be given as percentage(s) or dollar adjustment(s) and shall be included in 5.2.4 or 5.3. You must submit your responses in the order that is provided.

4.3.5.5 Offeror References

The offeror must furnish the following reference information:

Name, address, contact name, email, phone number, position of the contact in the organization, and telephone number for all clients, with at least 1,000 lives, who have terminated stop loss coverage with your organization in the last six (6) months. If there have been less than four (4) terminations in the last six (6) months, please provide information on the last four (4) terminated clients.

Name, address, contact name, email, phone number, position of the contact in the organization, and telephone number for all new clients, with at least 1,000 lives, who have added stop loss coverage with your organization in the last six (6) months. If there have been less than four (4) new clients in the last six (6) months, please provide information on the last four (4) new clients.

Name, address, contact name, email, phone number, position of the contact in the organization, and telephone number for three (3) existing stop loss clients, with at least 1,000 lives, and with three (3) or more year's history with the offeror.

Name, address, contact name, email, phone number, position of the contact in the organization and telephone number for the three (3) top public sector clients based on employee size.

Collin County may contact or visit any listed representative to evaluate the services proposed.

4.3.5.6 Sample Policy

The offeror shall submit with their proposal a sample of the policy that would be issued to Collin County if their proposal is selected. Please ensure that the provided policy fully describes any and all limitations and exclusions that may result in non-payment of benefits or alters any subrogation proceeds disbursement agreement contrary to the subrogation disbursement agreement set forth in paragraph 5.1.19.

Please clearly notate any changes that will need to be made on the sample policy. If there is a discrepancy between the responses on this RFP and the policy, the RFP responses will be the accepted responses and control over any policy language.

4.3.5.7 Errors and Omissions Coverage

A copy of the offeror's errors and omissions coverage should be provided.

4.3.5.8 Offeror Staff

The offeror must provide a résumé and other related data for each of the key personnel proposed to be assigned to Collin County's account. Information provided should accurately reflect the experience and expertise of the proposed staff, including the number of accounts managed, how many of those accounts are public sector and how many years of experience they have managing public sector accounts. Offeror agrees that Collin County may have a new account manager assigned to our account at any time, for any reason.

4.3.5.9 Experience

Please detail the length of time your organization has provided medical stop loss insurance services.

4.3.5.10 Litigation

Identify by court and case number any litigation against your organization, or in which your organization is a party, involving the same or similar services your organization would be providing to Collin County which have been filed in the last five (5) years.

4.3.5.11 Additional Information

Offerors should submit information describing in detail their qualifications, experience, and capabilities. Brochures, fact sheets, etc. may be submitted as appropriate to describe capabilities, experience, or any other pertinent information. References and experience with contracts for similar scope of work will be seriously considered during the selection process.

Please include any additional information which may be pertinent to this RFP. Collin County intends to consider all aspects of the proposed services in determining what is the best overall package for Collin County.

NOTE: FAILURE TO PROVIDE ALL INFORMATION REQUESTED MAY RESULT IN DISQUALIFICATION OF THE PROPOSAL.

4.4 EVALUATION PROCESS

4.4.1 Proposal Disclosure: In accordance with V.T.C.A Local Government Code 262.030 (c), proposals will be opened so as to avoid disclosure of the contents to competing offerors. The contents will be kept secret during the process of negotiation. However, all proposals will be open for public inspection after contract award. If identified by the offeror, and requested, information that qualifies as trade secrets and confidential information under the Texas Open Records Act will remain confidential.

4.4.2 Evaluation Factors: Collin County will consider many evaluation factors, of which price is only one factor. Offeror may be requested to make oral presentations on their respective proposals.

Factors	Points
Competitiveness of pricing and length of rate for services proposed	30
Capability/willingness to provide benefit plan with the ability to meet the needs of the County	25
Financial stability and stop loss coverage experience	20
Extent of electronic capability, such as electronic billing, enrollment, websites	10
Demonstrated effectiveness of services provided to other companies, including but not limited to references	15
Total	100

4.4.3 Award Information: The award of the contract shall be made to the responsible offeror(s) whose proposal is determined to be the best evaluated offer resulting from negotiation, taking into consideration the relative importance of price and other evaluation factors in paragraph 4.4.2 above. Collin County reserves the right to award on an “all or none” or by “service or coverage” basis.

Prompt payment discounts will not be considered in determining low proposals and making awards.

In consideration of the proposals, Collin County reserves the right to select one or more acceptable offerors who offer contractual terms and conditions most favorable to Collin County.

Collin County reserves the right to award all or a portion of the RFP.

5.0 PROPOSAL RESPONSE

5.1 PLAN ADMINISTRATION REQUIREMENTS

Please provide written confirmation of your agreement to the requirements listed below. Any coverage or services you cannot provide but are requested in the Request for Proposal, must be disclosed in writing in the section 5.3 labeled Deviations at the end of the proposal. If no deviations are listed in the section 5.3 labeled Deviations, it is understood that the offeror has

agreed to all requests as listed in the RFP. The offeror will be held strictly responsible for all items contained in the specific requirements.

5.1.1 The selected offeror will be responsible for all claims incurred that exceed the specific stop loss amount on or after the effective date of January 1, 2015, and within the contract period. All covered employees and their dependents shall not be adversely affected by a change in insurance carriers.

5.1.2 It is imperative that any exclusion, limitations or any other deviation be clearly outlined and discussed. Proposals received with full protection – no limitations – will receive preference.

5.1.3 The offeror must provide coverage that includes all employees and dependents regardless of “active at work” status, including retirees and their dependents and COBRA participants and their dependents. Offeror must also provide coverage to “late entrants” into Collin County’s health plans, such as new hires and those employees or dependents who experience a qualifying life event.

5.1.4 Stop loss coverage will include the following:

All employee participants and their covered dependents.

COBRA and Retiree participants and their covered dependents.

Employees who’s FMLA has expired and who did not elect COBRA coverage will not have to wait an additional 59 days for coverage when they return to work.

COBRA participants who do not receive a timely election notice.

Employees whose FMLA time is not started on time due to an administrative error. If such a situation occurs, the offeror will count FMLA time from the date the employee was actually placed on FMLA.

Adult children to age 26 as mandated by the Patient Protection and Affordable Care Act (PPACA).

Law enforcement employees who maintain employment with Collin County but are not actively at work. Collin County is mandated to continue coverage under Article 3, Section 52e of the Texas Constitution.

5.1.5 The offeror will be required, at any time during the contract/agreement, to supply the necessary current and historical data (as determined by Collin County) for inclusion in the next Request for Proposal at no cost to Collin County. Provision of such data will be provided according to the specifics requested by Collin County. The data must be provided within 15 business days of the request.

5.1.6 Collin County has a standard process for payment of all vendors which requires a 60 day payment grace period from due date of payment. Payment may be made by either

wire or check.

5.1.7 The offeror must notify Collin County of any billing/payment issues within 60 days in writing from the date the check was submitted to the offeror. Any billing/payment issues presented to the County after the 60-day date will not be reviewed or owed.

5.1.8 Collin County strives to accurately pay our bills in a timely manner. Should the offeror believe there is an outstanding balance the offeror shall research any outstanding balances to determine if the outstanding balance is truly owed before sending Collin County a notice of termination or non-payment. A detailed explanation of the outstanding balance must be provided in the termination/non-payment letter. The offeror must also provide Collin County 20 days from the date the non-payment letter is received by Collin County to submit payment.

5.1.9 Any written communications regarding plan administration issues sent by the offeror to Collin County must be mailed within 2 days of the date listed on the letter.

5.1.10 The offeror is responsible for preparing and providing to Collin County, for review and approval, a detailed administrative manual including procedural information on all agreed upon plan administration and claims procedures. Administrative manual should be submitted to Collin County within 30 days after contract becomes effective.

5.1.11 If coverage is denied due to an unintentional error or omission on the part of Collin County, the offeror will still provide coverage if coverage would have been provided had the unintentional error or omission not occurred.

5.1.12 Offeror must be able to work with any currently designated or future Third Party Administration (TPA). Our current TPA is UnitedHealthcare. Submitted claims must be processed within 15 days and paid within 30 days from the date of receipt from our TPA. In no case shall a claim be over 45 days old (excluding appeal time).

If claims are not paid in accordance with the timeframes listed above, Collin County reserves the right to penalize the offeror 1% of the total overdue claims from future premium payments. Any amount withheld from premium payments due to claims not being paid in a timely manner shall not be considered non-payment.

5.1.13 The offeror is also responsible for providing County employees training that is necessary to operate the offerors computer software. This also includes any other authorized training such as report writing training that might be requested by the plan administrator. Any costs associated with training must be clearly listed in your response.

5.1.14 Collin County self-bills based upon our eligible employee count. The offeror must agree to accept Collin County's self-billing each month. Any billing related documents must be provided in electronic format.

5.1.15 Annual renewal rates must be provided to Collin County a minimum of 120 days

prior to each renewal.

5.1.16 The offeror must agree to reimburse Collin County for 100% of covered medical expenses paid by our third party administrator, subject to applicable plan design. If the offeror decides to reimburse Collin County for any amount less than 100% of covered medical expenses, a written statement detailing the adjustments and the reason for the adjustments must be submitted to Collin County for approval.

5.1.17 The offeror agrees that any changes in eligibility or benefits mandated by the Patient Protection and Affordable Care Act (PPACA) or other legislation that is effective during the period of this policy will be accepted by the offeror.

5.1.18 Please confirm that you will provide ad hoc reports at no additional cost and/or that the County can run ad hoc reports from your website.

If the offeror must generate the requested reports, the offeror shall provide the reports, if necessary, on a timely basis, but in no case later than ten (10) working days after the request.

Should the nature of the additional reports warrant compensation beyond the bounds of this contract, the report shall be provided at a cost mutually agreeable between the County and the offeror. It is the offeror's responsibility to clearly communicate the cost of providing the requested report prior to producing the report. If the report is produced and the cost was not indicated to or approved by Collin County at the time of the request, Collin County will not be responsible for the cost of producing the report.

5.1.19 The offeror agrees that Collin County shall recover its full self-insured amount of \$100,000 before any recovered subrogation proceeds are distributed to the offeror. If the subrogation recovery is achieved through the efforts [whether by demand, settlement or litigation] of Collin County, then the offeror shall also reimburse Collin County the full cost of any litigation fees and services.

5.2 QUESTIONNAIRE

Instructions for completing questionnaire:

Answer all questions fully, clearly and concisely unless a specific question is inapplicable to the service you are proposing to provide. If you are unable to answer a question or the question does not apply, you should indicate either not applicable, or the reason why the question was not answered.

Each response must immediately follow the respective question. Do not refer to other parts of your proposal for the answers.

You may not modify either the order or language of the question.

5.2.1 General Questions

5.2.1.1 Is your stop loss coverage experience-rated or pooled? Please explain your renewal methodology.

5.2.1.2 Please describe the procedures that are followed when a contract terminates. Are there penalties or charges that would apply as a result of contract termination on the anniversary date? Off anniversary/early termination?

5.2.1.3 Three months prior to fiscal year end, September 30, will you provide a preliminary accounting on claims and estimated expenses?

5.2.1.4 What is your average administrative expense compared to the amount spent in claims for your stop loss accounts?

5.2.1.5 Do you agree not to give away or sell employee data, even “de-identified” data, with or without employee consent?

5.2.2 TPA Coordination Questions

5.2.2.1 Please provide a specific outline detailing how your services will coordinate with our health care third party administrator.

5.2.2.2 Please describe any data/reports that you would require from our third party administrator in order to process claims. Please provide the timeframes in which you would need to receive the information.

5.2.2.3 Please describe the information that you will request from Collin County or the designated third party administrator in order to process claims. If there is a specific form please provide a copy of the form. Please describe any additional information or materials you may require in order to process claims for payment.

5.2.2.4 Do you have the capability for electronic data interchange? Please list any third party administrator that your organization does not work with.

5.2.2.5 Please list TPA’s your organization currently works with and how many accounts you currently have who utilize your stop loss coverage with each.

5.2.3 Plan Design/Administration

5.2.3.1 Please describe the stop loss process that will be used for Collin County’s account, including information on claims tracking, filing and reporting services that will be provided.

5.2.3.2 Define “paid claim” as covered under your policy and the period of coverage.

5.2.3.3 Are any claims that are paid during the initial 12 month period excluded from the policy? If so please describe those claims in detail.

5.2.3.4 Please describe any limitations/exclusions you may have regarding filing a claim for reimbursement.

5.2.3.5 Collin County requires that the plan does not allow for carve outs or lasering of groups or individuals. In addition, there should be no limitations for specific illnesses, physical conditions or modifications of the stop loss amount for a specific insured.

5.2.3.6 Please indicate the percent of your accounts that are redlined, lasered or have a modification of the stop loss amount for a specific insured.

5.2.3.7 Do you offer any type of guaranteed renewal for future years? If so, under what parameters?

5.2.3.8 Please describe the mechanics for reimbursement, explain where claims are paid and identify who is ultimately responsible for determining whether or not reimbursement is due.

5.2.3.9 Provide the average length of time taken to process a claim, once received, based on all current claims in the last year.

5.2.3.10 Describe the quality controls, auditing and peer review mechanisms in place for your processing departments. Do you use internal or independent/outside auditors? How frequently do the audits occur? What specifically is audited?

5.2.3.11 Do you agree to offer Collin County the right to audit your organization's records and other relevant activity associated with its plan participants?

5.2.3.12 Please describe any plan limitations in your 12/12 and 12/15 contracts.

5.2.3.13 Describe the information you will need from Collin County in order to properly administer our account.

5.2.4 Financial Information

5.2.4.1 The requested quote for specific stop loss is for a \$100,000, 12/12 and 12/15 paid contract. In addition, please quote a specific stop loss for a \$150,000, \$200,000, 12/12 and 12/15 paid contracts.

Self-Funded Medical	Option #1	Option #2	Option #3	Option #4	Option #5	Option #6
Specific Amount	\$100,000	\$100,000	\$150,000	\$150,000	\$200,000	\$200,000
Contract Basis	12/12	12/15	12/12	12/15	12/12	12/15
Rates Per Employee Per Month						

5.2.4.2 Please provide a do not exceed rate for each of the options listed above. Any increase to the rates provided in 5.2.4.1 may not exceed the do not exceed rate. A rate increase may not be accepted by Collin County unless the offeror can demonstrate a direct correlation to the claims information provided by Collin County.

5.3 DEVIATIONS

Instructions for completing section

Please complete the following worksheet listing any and all deviations from the information requested in the RFP. Attach additional pages as needed. If no deviations are listed it is understood that the offeror has agreed to all requests as listed in the RFP.

Section Number/ Question Number	Required Service You are Unable to Perform	Steps Taken to Meet Requirement

Collin County
Attachment A - 2012 Dual Plan Summary
COLLIN COUNTY Medical Plans January 1, 2012

	ADVANTAGE		ADVANTAGE PLUS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre-existing Condition Limitations	None		None	
Plan Year Deductible (Individual/Family)	\$750/\$1,500	\$1,250/\$2,500	\$250/\$500	\$500/\$1,000
Out-of-Pocket Maximum (Individual/Family)	\$3,000/\$6,000	Does not apply	\$2,000/\$4,000	Does not apply
Physician Office Visit	\$20 Co-pay	Not Covered	\$15 Co-pay	Not Covered
Specialist Office Visit	\$50 Co-pay	Not Covered	\$40 Co-pay	Not Covered
Diabetes Related Physician Office Visit	\$0 Co-pay	Not Covered	\$0 Co-pay	Not Covered
Diabetes Related Specialist Office Visit	\$0 Co-pay	Not Covered	\$0 Co-pay	Not Covered
Urgent Care Center Services	\$25 Co-pay	Not Covered	\$25 Co-pay	Not Covered
Chiropractic Care	\$50 Co-pay	Not Covered	Plan pays 75%* (\$1,000 plan year max)	Not Covered
Lifetime Maximum	No Lifetime Maximum		No Lifetime Maximum	
Pharmacy Generic/Brand Name/Non-Preferred Generic/Brand Name & Non-Preferred	Retail Pharmacy \$10/\$25/\$50 Mail Order \$25/\$50	Not Covered	Retail Pharmacy \$10/\$25/\$50 Mail Order \$25/\$50	Not Covered
Diabetes Related Pharmacy Generic/Brand Name/Non-Preferred Generic/Brand Name & Non-Preferred	Retail Pharmacy \$0/\$0/\$0 Mail Order \$0/\$0	Not Covered	Retail Pharmacy \$0/\$0/\$0 Mail Order \$0/\$0	Not Covered
Well Care Benefits	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Emergency Health Services	Plan pays 80%*		Plan pays 75%*	
Durable Medical Equipment	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Inpatient Hospital Co-Payment: 3 person maximum	Plan pays 80%*	Not Covered	Plan pays 100% after a \$100 per day/\$500 co-payment maximum per admission*	Not Covered
Professional Fees for Surgical and Medical Services	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Outpatient Surgery	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Diagnostic Laboratory and X-ray	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Outpatient Diagnostic/Therapeutic Services	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Skilled Nursing Facility/Inpatient Physical Rehabilitation	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Hospice Care	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Home Health Care	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Ambulance Services	Plan pays 80%*		Plan pays 75%*	
Mental Health Services- Inpatient	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Mental Health Services- Outpatient	\$50 Co-pay (Individual) \$45 Co-pay (Group)	Plan pays 60%*	\$40 Co-pay	Plan pays 60%*
Allergy Shots, Serum and Testing	\$20 or \$50 Co-pay	Not Covered	Plan pays 75%*	Not Covered
Lasik Surgery	Plan pays 50%*, limited to \$2,000 per lifetime		Plan pays 50%*, limited to \$2,000 per lifetime	
Vision Care (part of medical plan)	See attached sheet		See attached sheet	
	Premium Discount Full-Time		Employee Monthly Contribution	
Employee Only	\$0.00		\$25.00	
Employee & Child(ren)	\$120.00		\$180.00	
Employee & Spouse	\$160.00		\$225.00	
Employee & Family	\$220.00		\$305.00	
	Premium Surcharge Full-Time		Employee Monthly Contribution	
Employee Only	\$50.00		\$75.00	
Employee & Child(ren)	\$170.00		\$230.00	
Employee & Spouse	\$210.00		\$275.00	
Employee & Family	\$270.00		\$355.00	

This document is intended as a convenient summary of the major points of these benefits plans. This document does not cover all provisions, limitations and exclusions. The official plan documents, policies and certificates of insurance govern in all cases.

*Subject to plan year deductible

Collin County
Attachment B - 2013 Dual Plan Summary
Collin County Medical Plans January 1, 2013

	ADVANTAGE		ADVANTAGE PLUS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre-existing Condition Limitations	None		None	
Plan Year Deductible (Individual/Family)	\$750/\$1,500	\$1,250/\$2,500	\$250/\$500	\$500/\$1,000
Out-of-Pocket Maximum (Individual/Family)	\$3,000/\$6,000	Does not apply	\$2,000/\$4,000	Does not apply
Physician Office Visit	\$20 Co-pay	Not Covered	\$15 Co-pay	Not Covered
Specialist Office Visit	\$50 Co-pay	Not Covered	\$40 Co-pay	Not Covered
Diabetes Related Physician Office Visit	\$0 Co-pay	Not Covered	\$0 Co-pay	Not Covered
Diabetes Related Specialist Office Visit	\$0 Co-pay	Not Covered	\$0 Co-pay	Not Covered
Urgent Care Center Services	\$25 Co-pay	Not Covered	\$25 Co-pay	Not Covered
Chiropractic Care	\$50 Co-pay	Not Covered	Plan pays 75%* (\$1,000 plan year max)	Not Covered
Lifetime Maximum	No Lifetime Maximum		No Lifetime Maximum	
Pharmacy	Retail Pharmacy	Not Covered	Retail Pharmacy	Not Covered
Generic/Brand Name/Non-Preferred	\$10/\$25/\$50		\$10/\$25/\$50	
Generic/Brand Name & Non-Preferred	Mail Order \$25/\$50		Mail Order \$25/\$50	
Tier 1 Contraceptives	Plan pays 100%		Plan pays 100%	
Women's Preventive Health	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Diabetes Related Pharmacy	Retail Pharmacy	Not Covered	Retail Pharmacy	Not Covered
Generic/Brand Name/Non-Preferred	\$0/\$0/\$0		\$0/\$0/\$0	
Generic/Brand Name & Non-Preferred	Mail Order \$0/\$0		Mail Order \$0/\$0	
Well Care Benefits	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Emergency Health Services	\$500 Co-pay, does not apply to deductible		\$500 Co-pay, does not apply to deductible	
Durable Medical Equipment	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Inpatient Hospital	Plan pays 80%*	Not Covered	Plan pays 100% after a \$100 per day/\$500 co-payment maximum*	Not Covered
Professional Fees for Surgical and Medical Services	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Outpatient Surgery	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Diagnostic Laboratory and X-ray	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Outpatient Diagnostic/Therapeutic Services	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Skilled Nursing Facility/Inpatient Physical Rehabilitation	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Hospice Care	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Home Health Care	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Ambulance Services	Plan pays 80%*		Plan pays 75%*	
Mental Health Services- Inpatient	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Mental Health Services- Outpatient	\$50 Co-pay (Individual) \$45 Co-pay (Group)	Plan pays 60%*	\$40 Co-pay	Plan pays 60%*
Allergy Shots, Serum and Testing	\$20 or \$50 Co-pay	Not Covered	Plan pays 75%*	Not Covered
Lasik Surgery	Plan pays 50%*, limited to \$2,000 per lifetime		Plan pays 50%*, limited to \$2,000 per lifetime	
Vision Care (part of medical plan)	See attached sheet		See attached sheet	
	Premium Discount Full-Time Employee Monthly Contribution		Premium Discount Full-Time Employee Monthly Contribution	
Employee Only	\$82.00		\$94.00	
Employee & Child(ren)	\$120.00		\$180.00	
Employee & Spouse	\$160.00		\$225.00	
Employee & Family	\$220.00		\$305.00	
	Premium Surcharge Full-Time Employee Monthly Contribution		Premium Surcharge Full-Time Employee Monthly Contribution	
Employee Only	\$132.00		\$144.00	
Employee & Child(ren)	\$170.00		\$230.00	
Employee & Spouse	\$210.00		\$275.00	
Employee & Family	\$270.00		\$355.00	

This document is intended as a convenient summary of the major points of these benefits plans. This document does not cover all provisions, limitations and exclusions. The official plan documents, policies and certificates of insurance govern in all cases.

Collin County
Attachment B - 2013 Dual Plan Summary
Collin County Medical Plans January 1, 2013

*Subject to plan year deductible

Attachment C - 2014 Dual Plan Summary
Collin County Medical Plans January 1, 2014

	ADVANTAGE		ADVANTAGE PLUS	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Pre-existing Condition Limitations	None		None	
Plan Year Deductible (Individual/Family)	\$750/\$1,500	\$1,250/\$2,500	\$250/\$500	\$500/\$1,000
Out-of-Pocket Maximum (Individual/Family)	\$3,000/\$6,000	Does not apply	\$2,000/\$4,000	Does not apply
Physician Office Visit	\$20 Co-pay	Not Covered	\$15 Co-pay	Not Covered
Specialist Office Visit	\$50 Co-pay	Not Covered	\$40 Co-pay	Not Covered
Diabetes Related - Physician Office Visit	\$0 Co-pay	Not Covered	\$0 Co-pay	Not Covered
Diabetes Related - Specialist Office Visit	\$0 Co-pay	Not Covered	\$0 Co-pay	Not Covered
Urgent Care Center Services	\$25 Co-pay	Not Covered	\$25 Co-pay	Not Covered
Chiropractic Care	\$50 Co-pay	Not Covered	Plan pays 75%* (\$1,000 plan year max)	Not Covered
Lifetime Maximum	No Lifetime Maximum		No Lifetime Maximum	
Pharmacy Generic/Brand Name/Non-Preferred Generic/Brand Name & Non-Preferred Tier 1 Contraceptives	Retail Pharmacy \$10/\$25/\$50 Mail Order \$25/\$50 Plan pays 100%	Not Covered	Retail Pharmacy \$10/\$25/\$50 Mail Order \$25/\$50 Plan pays 100%	Not Covered
Women's Preventive Health Services	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Diabetes Related Pharmacy Generic/Brand Name/Non-Preferred Generic/Brand Name & Non-Preferred	Retail Pharmacy \$0/\$0/\$0 Mail Order \$0/\$0	Not Covered	Retail Pharmacy \$0/\$0/\$0 Mail Order \$0/\$0	Not Covered
Well Care Benefits	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Emergency Health Services	\$500 Co-pay, does not apply to deductible		\$500 Co-pay, does not apply to deductible	
Durable Medical Equipment	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Inpatient Hospital	Plan pays 80%*	Not Covered	Plan pays 100% after a \$100 per day/\$500 co- payment maximum*	Not Covered
Professional Fees for Surgical and Medical Services	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Outpatient Surgery	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Diagnostic Laboratory and X-ray	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Outpatient Diagnostic/Therapeutic Services	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Skilled Nursing Facility/Inpatient Physical Rehabilitation	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Hospice Care	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Home Health Care	Plan pays 80%*	Not Covered	Plan pays 100%*	Not Covered
Ambulance Services	Plan pays 80%*		Plan pays 75%*	
Mental Health Services- Inpatient	Plan pays 80%*	Not Covered	Plan pays 75%*	Not Covered
Mental Health Services- Outpatient	\$50 Co-pay (Individual)	Plan pays 60%*	\$40 Co-pay	Plan pays 60%*
Allergy Shots, Serum and Testing	\$20 or \$50 Co-pay	Not Covered	Plan pays 75%*	Not Covered
Lasik Surgery	Plan pays 50%*, limited to \$2,000 per lifetime		Plan pays 50%*, limited to \$2,000 per lifetime	
Vision Care (part of medical plan)	See attached sheet		See attached sheet	
	Premium Discount Full-Time		Employee Monthly Contribution	
Employee Only	\$65.00		\$94.00	
Employee & Child(ren)	\$120.00		\$180.00	
Employee & Spouse	\$160.00		\$225.00	
Employee & Family	\$220.00		\$305.00	
	Premium Surcharge Full-Time		Employee Monthly Contribution	
Employee Only	\$90.00		\$144.00	
Employee & Child(ren)	\$170.00		\$230.00	
Employee & Spouse	\$210.00		\$275.00	
Employee & Family	\$270.00		\$355.00	

This document is intended as a convenient summary of the major points of these benefits plans. This document does not cover all provisions, limitations and exclusions. The official plan documents, policies and certificates of insurance govern in all cases.

*Subject to plan year deductible

Attachment D - 2012 Medical Plan Employee Premiums
Collin County Medical and Dental Monthly Rates
Plan Year 2012 (January 1 - December 31, 2012)

Plan Type	Full - Time Employees				Part - Time Employees			
	Employee Only	Employee & Child (ren)	Employee & Spouse	Employee & Family	Employee Only	Employee & Child (ren)	Employee & Spouse	Employee & Family
Advantage Premium Discount Plan	\$0.00	\$120.00	\$160.00	\$220.00				
Advantage Medical Plan	\$25.00	\$145.00	\$185.00	\$245.00	\$640.95	\$1,140.75	\$1,265.71	\$1,484.38
Advantage Premium Surcharge Plan	\$50.00	\$170.00	\$210.00	\$270.00				
Advantage Plus Premium Discount Plan	\$25.00	\$180.00	\$225.00	\$305.00				
Advantage Plus Medical Plan	\$50.00	\$205.00	\$250.00	\$330.00	\$711.20	\$1,267.20	\$1,406.21	\$1,649.47
Advantage Plus Premium Surcharge Plan	\$75.00	\$230.00	\$275.00	\$355.00				
Dental	\$2.00	\$24.00	\$24.00	\$24.00	\$25.77	\$75.55	\$75.55	\$75.55

A full-time employee and their spouse, if applicable, are eligible for a discounted rate when the current carrier notifies the county that a health assessment has been completed and their physician(s) completes a form with the following information: annual physical completed, well woman/well man exam completed if necessary, cholesterol screening completed, height/weight/body mass index provided. If this information is not completed, the employee and their spouse, if applicable, are defaulted to the premium surcharge plan. New hires are the only employees eligible for the rate in between, often referred to as the standard rate.

Attachment E - 2013 Medical Plan Employee Premiums
Collin County Medical and Dental Monthly Rates
Plan Year 2013 (January 1 - December 31, 2013)

Plan Type	Full - Time Employees					Part - Time Employees			
	Employee Only	Employee & Child (ren)	Employee & Spouse	Employee & Family		Employee Only	Employee & Child (ren)	Employee & Spouse	Employee & Family
Advantage Premium Discount Plan	\$82.00	\$120.00	\$160.00	\$220.00					
Advantage Medical Plan	\$107.00	\$145.00	\$185.00	\$245.00		\$668.33	\$1,202.99	\$1,336.67	\$1,570.59
Advantage Premium Surcharge Plan	\$132.00	\$170.00	\$210.00	\$270.00					
Advantage Plus Premium Discount Plan	\$94.00	\$180.00	\$225.00	\$305.00					
Advantage Plus Medical Plan	\$119.00	\$205.00	\$250.00	\$330.00		\$743.48	\$1,338.26	\$1,486.97	\$1,747.19
Advantage Plus Premium Surcharge Plan	\$144.00	\$230.00	\$275.00	\$355.00					
Dental	\$2.00	\$24.00	\$24.00	\$24.00		\$25.77	\$75.55	\$75.55	\$75.55

A full-time employee and their spouse, if applicable, are eligible for a discounted rate when the current carrier notifies the county that a health assessment has been completed and their physician(s) completes a form with the following information: annual physical completed, well woman/well man exam completed if necessary, cholesterol screening completed, height/weight/body mass index provided. If this information is not completed, the employee and their spouse, if applicable, are defaulted to the premium surcharge plan. New hires are the only employees eligible for the rate in between, often referred to as the standard rate.

Attachment F - 2014 Medical Plan Employee Premiums
Collin County Medical and Dental Monthly Rates
Plan Year 2014 (January 1 - December 31, 2014)

Plan Type	Full - Time Employees					Part - Time Employees			
	Employee Only	Employee & Child (ren)	Employee & Spouse	Employee & Family		Employee Only	Employee & Child (ren)	Employee & Spouse	Employee & Family
Advantage Premium Discount Plan	\$65.00	\$120.00	\$160.00	\$220.00					
Advantage Medical Plan	\$90.00	\$145.00	\$185.00	\$245.00		\$660.48	\$1,188.84	\$1,320.94	\$1,552.12
Advantage Premium Surcharge Plan	\$90.00	\$170.00	\$210.00	\$270.00					
Advantage Plus Premium Discount Plan	\$94.00	\$180.00	\$225.00	\$305.00					
Advantage Plus Medical Plan	\$119.00	\$205.00	\$250.00	\$330.00		\$734.74	\$1,322.52	\$1,469.48	\$1,726.64
Advantage Plus Premium Surcharge Plan	\$144.00	\$230.00	\$275.00	\$355.00					
Dental	\$2.00	\$24.00	\$24.00	\$24.00		\$27.95	\$88.53	\$88.53	\$88.53

A full-time employee and their spouse, if applicable, are eligible for a discounted rate when the current carrier notifies the county that a health assessment has been completed and their physician(s) completes a form with the following information: annual physical completed, well woman/well man exam completed if necessary, cholesterol screening completed, height/weight/body mass index provided. If this information is not completed, the employee and their spouse, if applicable, are defaulted to the premium surcharge plan. New hires are the only employees eligible for the rate in between, often referred to as the standard rate.

ATTACHMENT G – POLICY DATA - ADVANTAGE PLAN

Policy Holder Name	Collin County
Medical Policy Number	229670
Set Number	007ACIS
Effective Date	01/01/2014
Cancellation Date	99/99/9999
iBAAG Document Author	Praneeth Chary. N
Revision Reason	Plan Change

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN
Health Care Reform	<p><u>Summary of Benefits and Coverage (SBC)</u> <i>SBC Creation</i> Responsible Party: UHC</p> <p><i>Member Fulfillment</i> Responsible Party: Customer</p> <p><i>External Vendor (Carve-out)</i> Are external vendor benefits included in SBC? Pharmacy benefits - No Mental Health benefits - No</p> <p><u>Expanded Women’s Preventive Care Services Apply?</u> Yes</p> <p>Coverage guidelines for Expanded Women’s Preventive Care include:</p> <ul style="list-style-type: none"> • Breast-feeding support, supplies, and counseling. Click here for Network breast pump providers • Contraception methods and counseling • Domestic violence screening • Gestational diabetes screening • HIV screening and counseling • Human papillomavirus testing (beginning at age 30, and for every 3 years thereafter) • Sexually transmitted infections counseling • Well-woman visits <p>Click here for additional information on eligible services covered under the Expanded Women’s Preventive Care Services.</p>
Acquisition Integration Business Information	Acquisition/Integration applies? No

Business Segment	KEY ACCOUNTS
COSMOS To UNET Converted Case	Not Applicable
Product Year	2007
State of Issue	Texas
ERISA	No
Final Claim Fiduciary	<ul style="list-style-type: none"> • Urgent Care: UHC • 1st Level Pre-Service: UHC • 2nd Level Pre-Service: UHC • 1st Level Post-Service: UHC • 2nd Level Post-Service: UHC <ul style="list-style-type: none"> • Urgent /Escalated Appeals - All agents follow your current Urgent Appeals Guidelines. • Pre-Service - Submit written appeal to the P.O. Box address on the initial determination letter or UnitedHealthcare, P.O. Box 30432, Salt Lake City, Utah 84130-0432 • Post-Service - Submit written appeal as directed on the EOB or UnitedHealthcare, P.O. Box 30432, Salt Lake City, Utah 84130-0432 <p>The regulation requires that appeals be addressed in the following timeframes based on appeal type:</p> <ul style="list-style-type: none"> • Urgent appeals - 72 hours • Pre-service requests - 15 calendar days • Post service claims - 30 calendar days
COBRA Information	Administrator: United Healthcare Benefit Services Phone Number: 1-866-747-0048. Individual Medical Conversions allowed: No NOTE: For more information on Individual Medical Conversions please consult section 3.3 within CDS.
Coordination of Benefits COB	Other Insurance: Non-Duplication For secondary COB situations, does this customer follow the NAIC guideline to cover all non-covered benefits allowed by the primary carrier? Yes

	Medicare: Non-Duplication (Med 5)
Claim Filing Limit	You must submit a request for payment of Benefits within 1 year after the date of service. If you don't provide this information to us within 1 year of the date of service, Benefits for that health service will be denied or reduced, in our or the Claims Administrator's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. With respect to this claim filing limit, "you" refers to the member.
Covered Health Services	Covered Health Services are defined as those health services and supplies that are: <ul style="list-style-type: none"> • Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, mental illness, substance use or their symptoms; • Provided to a person who meets the Plan's eligibility requirements; and • Not identified as excluded.
Dependent Definition	<p>An eligible Dependent includes:</p> <ul style="list-style-type: none"> • The Participant's Spouse. • Any Dependent child under 26 years of age, including a natural child, a stepchild, a legally adopted child and a child for whom you or your Spouse are the legal guardian. • Coverage for Dependents terminates at the end of the month in which the child attains the maximum age. <p>Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.</p> <p>A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.</p> <p>To be eligible for coverage under the Policy, a Dependent must reside within the United States.</p>
Dependent Maternity Coverage	Yes

<p>Coverage for a Disabled Dependent Child</p>	<p>Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:</p> <ul style="list-style-type: none"> • Is not able to be self-supporting because of mental or physical handicap or disability. • Depends mainly on the Subscriber for support. <p>Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.</p> <p>We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.</p> <p>We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.</p> <p>If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.</p>
<p>Extended Coverage for Total Disability</p> <p>Total Disability or Totally Disabled - a Employees inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.</p>	<p>Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:</p> <ul style="list-style-type: none"> • The Total Disability ends. • 3 months from the date coverage would have ended when the entire Policy was terminated.
<p>Eligibility Contact</p>	<p>UHC</p>
<p>Facility Reasonable Customary</p>	<p>Yes</p> <ul style="list-style-type: none"> • Outpatient \$500 • Inpatient \$10,000
<p>Foreign-International Claims</p>	<p>Health services provided in a foreign country are not eligible,</p>

	unless required as Emergency Health Services.
Funding Arrangement	ASO
HIPAA	UHC sends out certificates of credible coverage.
Human Resource Contact	Contact: Collin County Phone Number: (972) 548-4605
Integrated Medical and Disability Support Program	Not Applicable
Care Coordination/C2	Not Applicable
Care Coordination	All Care Coordination sites are area code routed.
UnitedHealthcare Personal Health Support	Not Applicable
Medicare Crossover	Group is eligible for Medicare Crossover: No
Are Pre-existing Conditions covered?	Yes
R&C Tolerance Level	\$5 Medical/\$25 Surgical
Run In	Not Applicable
Shared Savings	Yes
Transition of Care – Pregnancy	2nd and 3rd trimester covered.

DEDUCTIBLES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
<p>Annual Deductible</p> <p><i>Definition of Annual Deductible</i> The Annual Deductible is the amount of eligible expenses you must pay each calendar year for Covered Health Services before the Plan begins paying for Eligible Expenses.</p> <p>The deductible applies to the service(s) where it is specifically identified in the sections below.</p>	<p>\$750 per Covered Person per calendar year, not to exceed \$1,500 for all Covered Persons in a family.</p>	<p>\$1,250 per Covered Person per calendar year, not to exceed \$2,500 for all Covered Persons in a family.</p>
<p>Per Occurrence Deductible</p> <ul style="list-style-type: none"> • 	<p>Network No Per Occurrence Deductible.</p>	<p>Non-Network No Per Occurrence Deductible.</p>

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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Deductible Cross Apply	No	No
Last Quarter Carry Over	No	No
<p>Limited Services Counting Method</p> <p>Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will</p>	Benefits which apply visit limitations will apply on the 1st claim.	

be reduced by the number of days/visits used toward meeting the Annual Deductible.	
Prorated Deductible and Out-of-Pocket	Does Proration apply? No

OUT OF POCKET

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
<p>Out-of-Pocket Maximum (OOPM)</p> <p>The Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services.</p> <p>If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.</p>	<p>\$3,000 per Covered Person per calendar year, not to exceed \$6,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Maximum does include the Annual Deductible.</p> <p>The following costs will never apply to the Out-of-Pocket Maximum:</p> <ul style="list-style-type: none"> ● Any charges for non-Covered Health Services. ● The amount of any reduced Benefits if you don't notify us as described in the section titled <i>Notification Requirements</i>. 	<p>No Out-of-Pocket Maximum</p>
<p>Out of Network Benefits</p>	<p>When Covered Health Services are received from non-Network providers, Eligible Expenses are determined based on either:</p> <p style="text-align: center;">Fee(s) that are negotiated with the provider.</p> <p style="text-align: center;">Available data resources of competitive fees in that geographic area.</p> <p>NOTE: If care is received from a non-network physician, facility, or other health care professional you will incur greater financial expense compared to an in-network provider. Your plan only pays a portion of those charges and it is your responsibility to pay the remainder. You are required to pay the amount that exceeds the allowable amount, which could be significant, and that amount does not apply to the Out-of-Pocket Maximum.</p>	

	We recommend you ask the non-network physician or health care professional about their billed charges before you receive care.	
<p>Maximum Plan Benefit</p> <p>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this plan.</p> <p>Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.</p>	No Maximum Plan Benefit	No Maximum Plan Benefit
Annual Maximum Benefit	No Annual Maximum Benefit.	

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Do deductibles apply to out-of-pocket?	Yes	No
Does the Per Occurrence Deductible apply to out-of-pocket?	Not Applicable	Not Applicable
Out-of-pocket Cross Apply	No	No

Inpatient confinement deductible applies to out-of-pocket	Not Applicable	Not Applicable
Copay emergency room apply to out-of-pocket	Yes	No
Copay office apply to out-of-pocket	Yes	Not Applicable
Copay Premium Designated office apply to out-of-pocket	Not Applicable	Not Applicable
Copay hospital apply to out-of-pocket	Not Applicable	Not Applicable
Copay Premium Designated hospital apply to out-of-pocket	Not Applicable	Not Applicable
Copay outpatient surgical facility apply to out-of-pocket	Not Applicable	Not Applicable
Copay urgent care center services apply to out-of-pocket	Yes	Not Applicable
Coinsurance apply to out of pocket	Yes	Yes
Out of Network Benefits	Not Applicable	80th percentile of R&C
Extended Non-Network Reimbursement Program (ENRP)	No	

COINSURANCE

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Patient Protection and Affordable Care Act (PPACA)	<p>Patient Protection Notices</p> <p>The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.</p>	

	<p>For children, you may designate a pediatrician as the primary care provider.</p> <p>You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.</p>	
<p>Coinsurance</p> <p>The percentage of Eligible Expenses payable by the plan for certain Covered Health Services after you meet the annual deductible.</p>	<p>In-Network Plan Level Coinsurance- 80% of eligible expenses after satisfying \$750 deductible until Out-of-Pocket is reached.</p>	<p>Out-of-Network Plan Level Coinsurance- 60% of eligible expenses after satisfying \$1,250 deductible until Out-of-Pocket is reached.</p>
<p>Copayment</p>	<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services.</p> <p>Please note that for each designated covered benefit category, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> ● The applicable Copayment. ● The Eligible Expense. <p>When Copayments apply, please refer to specific benefit category for the reimbursement policy.</p> <p>Details about the way in which Eligible Expenses are determined appear in the benefit category of <i>Eligible Expenses</i> further below.</p>	
<p>Eligible Expenses</p> <p>Eligible Expenses are the amount we determine that we will pay for Benefits.</p> <p>Definition of an Eligible Expense: For Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated</p>	<p>For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the Summary Plan Description.</p> <p>If one or more alternative health services that meets the</p>	<p>For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.</p> <p>When Covered Health Services are received from a non-Network provider, Eligible Expenses are</p>

<p>below.</p> <p>Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:</p> <ul style="list-style-type: none"> • As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS). • As reported by generally recognized professionals or publications. • As used for Medicare. • As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept. 	<p>definition of Covered Health Service in the benefit categories of Mental Health and Substance Use Disorder are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, Substance Use Disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.</p> <p>For Network Benefits, Eligible Expenses are based on either of the following:</p> <ul style="list-style-type: none"> • When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider. • When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated. 	<p>determined, at our discretion, based on the lesser of:</p> <ul style="list-style-type: none"> • For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area. • When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 100% of the amount that the Centers for Medicare and Medicaid Services (CMS) would have paid under the Medicare program for the drug determined by either of the following: Reference to available CMS schedules. Methods similar to those used by CMS. • Fee(s) that are negotiated with the provider. • 50% of the billed charge. • A fee schedule that we develop.
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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
None		
None		

FLEXIBLE SPENDING ACCOUNT

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN
FSA Vendor	<ul style="list-style-type: none"> • Administered by: UnitedHealthcare • Call 1-800-331-0480 <p>Does the Limited Purpose Flexible Spending Account apply? No</p>
Retiree Reimbursement Account (RRA)	Not Applicable
UnitedHealthcare Consumer Accounts Card	No

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
None		
None		

HOSPITAL SERVICES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Accessing Benefits	<p>You can choose to receive Network Benefits or Non-Network Benefits.</p> <p>Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as Network Benefits.</p> <p>Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.</p>	

	<p>You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.</p> <p>Health Services from Non-Network Providers Paid as Network Benefits</p> <p>If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.</p>	
<p>Notification Requirements</p> <p>Special Note Regarding Medicare</p> <p>If you are enrolled in Medicare and Medicare pays benefits before the Plan, you are not required to notify us before receiving Covered Health Services.</p>	<p>Prior notification is required before you receive certain Covered Health Services.</p> <p>You are responsible for notifying us before you receive the following Covered Health Services:</p> <ul style="list-style-type: none"> • Clinical Trials • Dental Services -Accident Only • Emergency Health Services if you are admitted to a non-Network Hospital. • Reconstructive Procedures • As soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). <p>Please refer to the Mental Health and Substance Use Disorder section for notification requirements pertaining to Mental Health and Substance Use Disorder treatment.</p> <p>**REFER TO SPECIFIC BENEFIT SECTION FOR APPLICABLE PENALTIES FOR NOTIFICATION</p>	<p>Prior notification is required before you receive certain Covered Health Services.</p> <p>You are responsible for notifying us before you receive the following Covered Health Services:</p> <ul style="list-style-type: none"> • Clinical Trials • Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery; • Skilled Nursing Facility/ Inpatient Rehabilitation Facility • Hospital-Inpatient Stay including Emergency admission • Temporomandibular Joint Services • As soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). • As soon as Congenital Heart Disease is suspected or diagnosed (in utero detection, at birth, or as determined and before the time an evaluation for CHD is performed).

		<ul style="list-style-type: none"> You must notify us before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item.) Prosthetic devices over \$1,000 in cost per device <p>If you don't notify us, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>Please refer to the Mental Health and Substance Use Disorder section for notification requirements pertaining to Mental Health and Substance Use Disorder treatment.</p> <p>**REFER TO SPECIFIC BENEFIT SECTION FOR APPLICABLE PENALTIES FOR NOTIFICATION</p>
<p>Ambulance Services – Emergency Only</p> <p>Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. Air transportation is covered if ground transportation is impossible or would put your life or health in serious jeopardy.</p>	<p>Ground Transportation:</p> <p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>.</p> <p>Air Transportation:</p> <p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>Ground Transportation:</p> <p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>Air Transportation:</p> <p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Ground Transportation:</p> <p>80% of eligible expenses after satisfying \$750 Network deductible.</p> <p>Air Transportation:</p> <p>80% of eligible expenses after satisfying \$750 Network deductible.</p> <p>Ground Transportation:</p> <p>80% of eligible expenses after satisfying \$750 Network deductible.</p> <p>Air Transportation:</p> <p>80% of eligible expenses after satisfying \$750 Network deductible.</p>

<p>Ambulance Services - Non-Emergency The Plan also covers transportation provided by licensed professional ambulance, other than air ambulance, (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:</p> <ul style="list-style-type: none"> • From a non-Network Hospital to a Network Hospital; • To a Hospital that provides a higher level of care that was not available at the original Hospital; • To a more cost-effective acute care facility; or • From an acute facility to a sub-acute setting. 	<p>Not Covered</p>	<p>Not Covered</p>
<p>Ambulatory Surgical Center</p>	<p>Refer to <i>Surgery Outpatient</i> benefit below for a description of Covered Health Services.</p>	<p>Not Covered.</p>
<p>Emergency Health Services- Outpatient</p> <p>Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.</p>	<p>\$500 copay then 100% of eligible expenses.</p> <p>If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services.</p> <p>Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency. (Non-emergency services are not covered.)</p>	<p>Same as Network Benefit</p> <p>If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services.</p> <p>Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency. (Non-emergency services are not covered.)</p> <p>Notification Required</p>

		<p>Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify us within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital or Alternate Facility</p> <p>If you don't notify us, Benefits for the Hospital Inpatient Stay will be reduced to 50% of Eligible Expenses.</p>
<p>Hospital Inpatient Stay</p> <p>If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room is not an allowable expense (unless the patient's stay in a private Hospital room is necessary in terms of generally accepted medical practice.)</p> <p>Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described under <u>Physician Fees for Surgical and Medical Services.</u></p> <p>Inpatient Stay in a Hospital. Benefits are available for:</p> <ul style="list-style-type: none"> ● Services and supplies received during the Inpatient Stay. ● Room and board in a Semi-private Room (a room with two or more beds). ● Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. 	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered</p>

<p>Benefits for Emergency admissions and admissions of less than 24 hours are described under <u>Emergency Health Services-Outpatient, Surgery – Outpatient, Scopic Procedures – Diagnostic</u> and <u>Therapeutic Treatments – Outpatient</u>, respectively.</p> <p>UnitedHealth PremiumSM Program UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:</p> <ul style="list-style-type: none"> ● help you make informed decisions on where to receive care; ● provide you with decision support resources; and ● give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria. <p>For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto www.myuhc.com or call the toll-free number on your ID card.</p>		
<p>Lab, X-Ray and Diagnostics – Outpatient</p> <p>Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:</p> <ul style="list-style-type: none"> ● lab and radiology/x-ray; and ● mammography 	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered</p>

<p>Benefits under this section include:</p> <ul style="list-style-type: none"> • the facility charge and the charge for supplies and equipment; and • Physician services for anesthesiologists, pathologists and radiologists. <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services - Sickness and Injury</i>.</p> <p>Benefits for other Physician services are described in this section under <i>Physician Fees for Surgical and Medical Services</i>. Lab, X-ray and diagnostic services for preventive care are described under <i>Preventive Care Services</i>.</p> <p>Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine – Outpatient Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Benefits under this section include:</p> <ul style="list-style-type: none"> • the facility charge and the charge for supplies and equipment; and • Physician services for anesthesiologists, pathologists and radiologists. <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services - Sickness and Injury</i>.</p> <p>Benefits for other Physician</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered</p>
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<p>services are described under <i>Physician Fees for Surgical and Medical Services</i>.</p> <p>Note: Radiology notification required for outpatient MRI/MRA Scans, CT Scans, PET Scans and Nuclear Medicine Studies for services rendered by a Network Provider. The Network Provider will be sanctioned for non-notification. Network Providers Only - please select the "Radiology/ Notification prompt when confirming benefits for these services.</p>		
<p>Scopic Procedures – Outpatient Diagnostic and Therapeutic</p> <p>The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.</p> <p>Benefits under this section include:</p> <ul style="list-style-type: none"> • The facility charge and the charge for supplies and equipment; and • Physician services for anesthesiologists, pathologists and radiologists. <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services - Sickness and Injury</i>.</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered</p>

<p>Benefits for other Physician services are described under <i>Physician Fees for Surgical and Medical Services.</i></p> <p>Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under <i>Surgery - Outpatient.</i> Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.</p>		
<p>Surgery-Outpatient</p> <p>The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Benefits under this section include:</p> <ul style="list-style-type: none"> • The facility charge and the charge for supplies and equipment; and • Certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy) • Physician services for anesthesiologists, pathologists and radiologists. <p>Benefits for other Physician services are described under <u><i>Physician Fees for Surgical and Medical Services.</i></u></p> <p>When these services are performed in a Physician's office, Benefits are described under <u><i>Physician's Office Services – Sickness and Injury.</i></u></p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered</p>

<p>Note: Radiology notification required for outpatient MRI/MRA Scans, CT Scans, PET Scans and Nuclear Medicine Studies for services rendered by a Network Provider. The Network Provider will be sanctioned for non-notification. Network Providers Only - please select the "Radiology/ Notification prompt when confirming benefits for these services.</p>		
<p>Therapeutic Treatments – Outpatient</p> <p>The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.</p> <p>Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:</p> <ul style="list-style-type: none"> • education is required for a disease in which patient self-management is an important component of treatment; and • there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional <p>Benefits under this section include:</p> <ul style="list-style-type: none"> • the facility charge and the charge for related supplies and equipment; and • Physician services for 	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered</p>

<p>anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under <u>Physician Fees for Surgical and Medical Services</u></p> <p>When these services are performed in a Physician's office, Benefits are described under <u>Physician's Office Services – Sickness and Injury</u></p>		
<p>Urgent Care Center Services</p> <p>Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under <u>Physician's Office Services – Sickness and Injury</u>.</p> <p>If the services is provided in an Urgent Care Center and the Urgent Care benefit is a flat dollar copayment, then benefits for the following will pay under the Urgent Care copay</p>	<p>\$25 copay per visit, then 100% of eligible expenses.</p>	<p>Not Covered</p>

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
<p>Intensive Care Unit</p> <p>UnitedHealth PremiumSM Program UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered</p>

<p>Premium Program was designed to:</p> <ul style="list-style-type: none"> ● help you make informed decisions on where to receive care; ● provide you with decision support resources; and ● give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria. <p>For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto www.myuhc.com or call the toll-free number on your ID card.</p>		
<p>Pre-Admission Testing</p>	<p>Refer to the appropriate benefit category.</p> <p>If services are rendered in an outpatient facility refer to the Outpatient Diagnostic benefit, which is described in the <i>Surgery - Outpatient</i> benefit category.</p> <p>If services are rendered in an office setting refer to the <i>Physician's Office Services – Sickness and Injury</i> benefit category.</p>	<p>Refer to the appropriate benefit category.</p> <p>If services are rendered in an outpatient facility refer to the Outpatient Diagnostic benefit, which is described in the <i>Surgery - Outpatient</i> benefit category.</p> <p>If services are rendered in an office setting refer to the <i>Physician's Office Services – Sickness and Injury</i> benefit category.</p>

MATERNITY CARE

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
<p>Pregnancy – Maternity Services</p> <p>Includes prenatal care, delivery, postnatal care and any related complications.</p> <p>We will pay Benefits for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> ● 48 hours for the mother and 	<p>Same as:</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i> 	<p>Not Covered.</p>

<p>newborn child following a normal vaginal delivery.</p> <ul style="list-style-type: none"> • 96 hours for the mother and newborn child following a cesarean section delivery. <p>These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay.</p> <p>If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.</p> <p>Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.</p> <p>The following services are not covered:</p> <ul style="list-style-type: none"> • Services provided by a doula (labor aide); • Parenting, pre-natal or birthing classes; 	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	
<p>Neonatal Resource Services (NRS)</p>	<p>Not Applicable</p>	<p>Not Applicable</p>
<p>Newborn Care</p> <p>Non-wellness services for a newborn child whose length of stay in the hospital exceeds the mother's length of stay.</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered.</p>
<p>Midwife</p>	<p>Covered same as Pregnancy - Maternity Services and</p>	<p>Not Covered.</p>

	<i>Newborn Care</i> sections above.	
Birthing Center	Covered same as <i>Pregnancy - Maternity Services</i> and <i>Newborn Care</i> sections above.	Not Covered.
The Healthy Pregnancy Program	<p>A healthy pregnancy is the first step to a healthy baby and mom. The Healthy Pregnancy Program provides pregnancy consultation to identify special needs, written and on-line educational materials and resources, 24-hour toll-free access to experienced maternity nurses, and a phone call from a care coordinator during your pregnancy and about four weeks after your baby is born to see how things are going and answer questions you may have.</p> <p>Call 1-800-411-7984 Or Visit www.healthy-pregnancy.com</p>	Not Covered.

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Newborn Process	The child is automatically covered for a 31 -day period under the employees SSN as "Baby Boy or Baby Girl." Claims incurred/submitted during this period of time will be paid. Any claims received after the 31 -day period, (for DOS after the 31 days post-birth), will be denied unless child has already been added as a dependent.	

PHYSICIAN SERVICES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
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<p>Anesthesia</p>	<p>Services provided by facility based RAPLEs (i.e., radiologists, anesthesiologists, pathologists, labs, emergency room physicians) are covered as part of the facility benefit as described under <i>Hospital Inpatient Stay, Emergency Health Services - Outpatient</i> or <i>Surgery – Outpatient</i> categories. RAPL services associated with outpatient lab/diagnostics are described under the <i>Lab, X-ray and Diagnostics – Outpatient</i> benefit.</p>	<p>Services provided by facility based RAPLEs (i.e., radiologists, anesthesiologists, pathologists, labs, emergency room physicians) are covered as part of the facility benefit as described under <i>Hospital Inpatient Stay, Emergency Health Services - Outpatient</i> or <i>Surgery – Outpatient</i> categories. RAPL services associated with outpatient lab/diagnostics are described under the <i>Lab, X-ray and Diagnostics – Outpatient</i> benefit.</p>
<p>Hemophilia Program</p>	<p>The following is excluded from coverage under the Specialty Pharmacy program:</p> <ul style="list-style-type: none"> • Hemophilia 	
<p>Nutritional Counseling</p> <p>Nutritional education provided in a Physician’s office by an appropriately licensed or healthcare professional when required for a disease in which patient self-management is an important component of treatment or there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.</p> <p>Some examples of such medical conditions include:</p> <ul style="list-style-type: none"> • Coronary artery disease; • Congestive heart failure; • Severe obstructive airway disease; • Gout; • Renal failure; • Phenylketonuria; and • Hyperlipidemias. <p>The following services are not</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>When nutritional counseling services are billed as a preventive care service, these services will be paid as described under <i>Preventive Care Services</i>.</p>	<p>Not Covered</p>

<p>covered:</p> <ul style="list-style-type: none"> ● Nutritional counseling for either individuals or groups, except as identified under Diabetes Services and except as defined in this category; ● Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy, ● Food of any kind. Foods that are not covered include: <ul style="list-style-type: none"> ● Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk; unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded ● Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; ● Oral vitamins and minerals; ● Meals you can order from a menu, for an additional charge, during an Inpatient Stay; and ● Other dietary and electrolyte supplements; and ● Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes. 		
<p>Physician's Office Services – Sickness and Injury</p>	<p>\$20 Primary Physician/ \$50 Specialist copay per visit then</p>	<p>Not Covered</p>

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Covered Health Services for Preventive Care provided in a Physician's office are described under *Preventive Care Services*. Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office.

Note - If the service is provided in a Physician Office Setting and the Physician Office benefit is a flat dollar copayment, then benefits for the following will pay under the office visit copay:

- Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine – Outpatient
- Pharmaceutical Products - Outpatient
- Scopic Procedures - Outpatient Diagnostic
- Surgery – Outpatient

100% of eligible expenses.

No copayment applies when no Physician charge is assessed.

<ul style="list-style-type: none"> • Therapeutic Treatments - Outpatient <p>Refer to <i>Rehabilitation Therapy</i> for a description of benefit coverage.</p> <p>UnitedHealth PremiumSM Program UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:</p> <ul style="list-style-type: none"> • help you make informed decisions on where to receive care; • provide you with decision support resources; and • give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria. <p>For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto www.myuhc.com or call the toll-free number on your ID card.</p>		
<p>Preventive Care</p> <p>Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial</p>	<p>100% of eligible expenses.</p>	<p>Non-Network Benefits are not available.</p>

effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing; and
- tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your

provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.		
Physician Fees for Surgical and Medical Services When these services are performed in a Physician's office, Benefits are described under Physician's Office Services.	80% of eligible expenses after satisfying \$750 deductible.	Not Covered
Second Surgical Opinion This is not a required service to obtain benefits.	Physician Office Services: \$20 copay per visit then 100% of eligible expenses. Specialist Office Services: \$50 copay per visit then 100% of eligible expenses.	Not Covered
Vision Care Routine vision exam is not a covered benefit under this plan. Member needs to be referred to their Spectera vision plan.	Not Covered For Vision Care contact: UnitedHealthcare Vision 1-800-638-3120 Please contact UnitedHealthcare Vision to verify eligibility and coverage for routine vision.	Not Covered

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Assistant Surgeon	80% of eligible expenses after satisfying \$750 deductible.	Not Covered
Cochlear Implants	Same as <ul style="list-style-type: none"> ● <i>Physician's Office Services</i> ● <i>Physician Fees for Surgical and Medical</i> ● <i>Hospital-Inpatient Stay</i> 	Not Covered

	<ul style="list-style-type: none"> • <i>Surgery-Outpatient</i> • <i>Durable Medical Equipment</i> 	
Hemophilia Quick Tip	<p>This program only supports obtaining medications from a specific provider. Depending on the place of service, benefit information can be located within several applicable benefit categories.</p> <ul style="list-style-type: none"> • If Hemophilia Factor is a part of a carve-out situation, the carve-out Pharmacy Benefit Manager and/or Specialty Pharmacy vendor should be contacted to confirm coverage. • If administered on an outpatient basis in a Hospital, Alternate Facility, Physician's Office, or administered or directly supervised by a qualified provider or licensed/certified health professional in a Covered Persons' residence (during eligible Home Health Care or Physician House Calls) refer to <i>Pharmaceutical Products – Outpatient</i>. • If administered during an Emergency room visit, refer to <i>Emergency Health Services – Outpatient</i> for more information. • If self-administered (self-injected, self-infused, etc), refer to <i>Prescription Drugs</i> for more information. <p>For more information on coverage determination guidelines and codes, please use the <u>Specialty Pharmacy SOP</u> link.</p> <p><u>Exceptions - Lock out codes:</u> ASO clients who have opted into the Specialty Pharmacy Program can choose to opt out of certain therapeutic classes. The following opt outs exist and should be reflected in the <i>Specialty Pharmacy Program</i> section above – specifically the therapeutic class should be removed from the list and there should be a call out that that particular therapeutic class has been excluded from the program. A client can only opt out of one of the options below. This will be a very rare occurrence.</p> <ul style="list-style-type: none"> • Hemophilia • See <i>Specialty Pharmacy Program Quick tip</i> section for other classes that may be excluded as part of the Specialty Pharmacy Program 	
Multiple Surgical Procedures	100/50/50	100/50/50
Network Gap Exception – No Physician/Specialist within 30 miles of their home zip code.	Exception granted through care coordination ONLY prior to receipt of care. Exception will be documented in the CCS View/ARI screens if approved by Care Coordination.	
Non-Network Office Based Lab and Diagnostic Processing	New Processing applies to Lab and Diagnostic services. Explanation: Benefits for lab/diagnostics services will be based solely on the	

	network status of the lab/diagnostic provider, regardless of the network status of the ordering physician.
Preventive Care SPI Bundle	This plan has elected coverage for additional services under the preventive care benefit beyond what is required by the federal health reform law (a/k/a PPACA or the Affordable Care Act). Refer to the <u>Preventive SPI Bundle Job Aid</u> in Knowledge Library for a list of the additional services covered by this plan as preventive.
RAPS Processing	RAPLE = Radiologist, Anesthesiologist, Pathologist, Laboratory and Emergency Room Physician. RAPLE- Reimbursement of Out-of -network RAPLE providers is determined by the network status of the inpatient hospital or outpatient surgical facility. In network benefits follow the Inpatient Hospital or Outpatient Surgery benefit category.

FAMILY PLANNING

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Birth Control Pills	See <i>Prescription Drug Section</i> for pharmacy benefits.	See <i>Prescription Drug Section</i> for pharmacy benefits.
ParentSteps^(SM)	<p>ParentSteps Infertility Centers of Excellence Network provides access to some of the best infertility clinics in the country. These clinics have high pregnancy rates AND low incidence of multiple births. ParentSteps offers the ability to purchase treatment cycles and infertility medications at group discount prices. ParentSteps also provides infertility nurse specialists who can educate you on your diagnosis and treatment options.</p> <p>For information concerning infertility treatment, please visit ParentSteps at www.myoptumhealthparentsteps.com or call 1-866-774-4626.</p>	
Reproductive Resource Services Program (RRS)	Not Applicable.	
Infertility Services	80% of eligible expenses after satisfying \$750 deductible. The following service is covered:	Not Covered

	<ul style="list-style-type: none"> • Diagnosis of underlying condition only. <p>The following services are not covered:</p> <ul style="list-style-type: none"> • Health services and associated expenses for infertility treatments. • Artificial Insemination, • GIFT, and ZIFT Office visits are limited to \$5,000 per lifetime. 	
<p>Reproduction</p> <p>Female contraceptive services, supplies and voluntary sterilization are covered the same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.</p>	<p>Same as:</p> <ul style="list-style-type: none"> • <i>Physician's Office Services – Sickness and Injury</i> • <i>Physician Fees</i> • <i>Hospital-Inpatient Stay</i> • <i>Lab, X-ray and Diagnostics – Outpatient</i> • <i>Therapeutic Treatments - Outpatient</i> <p>Applicable services:</p> <ul style="list-style-type: none"> • Voluntary sterilization. • Fetal reduction surgery <p>Refer to Reproduction-Exclusions for services that are not covered.</p>	<p>Not Covered</p>
<p>Reproduction-Exclusions</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> • 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. • • in vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility; • surrogate parenting, donor eggs, donor sperm and host uterus; • the reversal of voluntary sterilization • artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes; • elective surgical, non-surgical or drug induced Pregnancy termination; This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage) • services provided by a doula (labor aide); and • parenting, pre-natal or birthing classes 	

Tubal Ligation	Female contraceptive services, supplies and voluntary sterilization are covered the same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.	Female contraceptive services, supplies and voluntary sterilization are covered the same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.
Vasectomy	Same as: <ul style="list-style-type: none"> ● <i>Physician's Office Services - Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Surgery - Outpatient</i> 	Same as: <ul style="list-style-type: none"> ● <i>Physician's Office Services - Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Surgery - Outpatient</i>

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Diaphragm Covered for device, fitting and removal. Female contraceptive services, supplies and voluntary sterilization are covered the same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.	100% of eligible expenses.	Non-Network Benefits are not available.
Depo Provera Female contraceptive services, supplies and voluntary sterilization are covered the same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.	100% of eligible expenses.	Non-Network Benefits are not available.
IUD Covered for device, fitting and removal.	100% of eligible expenses.	Non-Network Benefits are not available.

<p>Female contraceptive services, supplies and voluntary sterilization are covered the same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.</p>		
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SPECIAL SERVICES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Acupuncture Services	Not Covered.	Not Covered.
Allergy Care	<p>\$20 Primary Physician/ \$50 Specialist copay per visit then 100% of eligible expenses.</p> <p>No copayment applies when no Physician charge is assessed.</p>	Not Covered
Bariatric Resource Services (BRS)	Not Applicable.	
<p>Breast Pumps</p> <p>Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth.</p> <p>Benefits are only available if breast pumps are obtained from a DME provider or Physician.</p>	100% of eligible expenses.	Not Covered.

<p>Cancer Resource Services (CRS)</p>	<p>Access to the CRS Centers of Excellence Network gives patients care that is planned, coordinated and provided by a team of experts who specialize in their specific cancer. Potential benefits include accurate diagnosis, appropriate therapy (neither too little nor too much), higher survival rates and decreased costs.</p> <p>Network benefits are available for patients who receive care at a designated Cancer Resource Services Network facility.</p> <p>Participation in this program is voluntary for the enrollee. To ensure network benefits are received under this program, patients, or someone on their behalf, must contact Cancer Resource Services at 1-866-936-6002 before receiving care. More information is also available at www.myoptumhealthcomplexmedical.com</p> <p>Travel and Lodging Assistance is not available as part of the Cancer Resource Services program.</p>	
<p>Chemotherapy</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered</p>
<p>Clinical Trials</p> <p>Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:</p> <ul style="list-style-type: none"> • Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted; • Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below; • Surgical musculoskeletal disorders of the spine, hip, 	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category.</p> <p>Pre-service Notification Requirement You must notify us as soon as the possibility of participation in a clinical trial arises.</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category.</p> <p>Pre-service Notification Requirement You must notify us as soon as the possibility of participation in a clinical trial arises.</p> <p>If you don't notify us, Benefits will be reduced to 50% of Eligible Expenses .</p>

<p>and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below; and</p> <ul style="list-style-type: none"> • Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below. <p>Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.</p> <p>Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher.</p> <p>Routine patient care costs for clinical trials include:</p> <ul style="list-style-type: none"> • Covered Health Services for which Benefits are typically provided absent a clinical trial. • Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications. • Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service. 		
<p>Congenital Heart Disease Resource Services (CHDRS)</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>Access to the CHD Centers of</p>	<p>Not Covered</p>

	<p>Excellence Network gives patients care that is planned, coordinated and provided by a team of experts who specialize in treating Congenital Heart Disease. Potential benefits include accurate diagnosis, appropriate surgical interventions, higher survival rates and decreased costs.</p> <p>Network benefits are available for patients who receive care at a designated CHD Centers of Excellence Network facility.</p> <p>Participation in this program is voluntary for the enrollee. To help ensure network benefits are received under this program, patients, or someone on their behalf, should contact CHD Resource Services at 1-888-936-7246 before receiving care. More information is also available online.</p> <p>Travel and Lodging Assistance is available as part of the Congenital Heart Disease Resource Services program. \$50/\$100 per diem with a Lifetime Maximum of \$10,000.</p>	
<p>Dental Services – Accident Only</p> <p>Dental services are covered by the Plan when all of the following are true:</p> <ul style="list-style-type: none"> • treatment is necessary because of accidental damage; • dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth; • dental services are received from a Doctor of Dental 	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered</p>

Surgery or a Doctor of Medical Dentistry; and

- the dental damage is severe enough that initial contact with a Physician or dentist occurs within **72** hours of the accident. (You may request an extension of this time period provided that you do so within **60** days of the Injury and if extenuating circumstances exist due to the severity of the Injury)

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate

Dental services for final treatment to repair the damage caused by accidental Injury must be started within **3** months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within **12** months of the accident.

The Plan pays for treatment of accidental Injury only for:

- emergency examination
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;

- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Please remember that you should notify us as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification, before the initial Emergency treatment. When you provide notification, we can determine whether the service is a Covered Health Service.

The following services are not covered:

- 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.
- Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:
 - extractions (including wisdom teeth);
 - restoration and replacement of teeth;
 - medical or surgical treatments of dental conditions; and
 - services to improve dental clinical outcomes;
- dental implants, bone grafts, and other implant-related

<p>procedures;</p> <ul style="list-style-type: none"> ● dental braces (orthodontics); ● dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia (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 as described above; and ● treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate. 		
<p>Durable Medical Equipment</p> <p>The plan pays for Durable Medical Equipment that is:</p> <ul style="list-style-type: none"> ● Ordered or provided by a Physician for outpatient use; ● Used for medical purposes; ● Not consumable or disposable; ● Not of use to a person in the absence of a sickness, injury or disability; ● Durable enough to withstand repeated use; and ● Appropriate for use in the home. <p>If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered</p>

unit. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- insulin pumps and all related necessary supplies as described under ***Diabetes Services***;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute

<p>respiratory failure or conditions.</p> <p>The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with Durable Medical Equipment.</p> <p>Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.</p> <p>Foot Orthotics -should be covered combined with DME</p> <p>Notification Required</p> <p>Please remember that for Benefits you must notify us before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (purchase, rental, repair or replacement of Durable Medical Equipment).</p> <p>If you don't notify us, Benefits will be reduced to 50% of Eligible Expenses</p>		
<p>Foreign Travel</p> <p>Do not cover flights back to the United States from a foreign country under any circumstance</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Healthy Back Program</p>	<p>Not Applicable</p>	
<p>Healthy Weight Program</p>	<p>Not Applicable</p>	
<p>Hearing Aids</p>		<p>Not covered</p>

<p>Coverage for hearing loss as the result of an accidental injury only.</p> <p>The Plan pays Benefits for hearing aids which are required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.</p> <p>Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.</p> <p>Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:</p> <ul style="list-style-type: none"> ● craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or ● hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. 	<p>50% of eligible expenses after satisfying \$750 deductible.</p> <p>Coverage for accidental injury only</p>	
<p>Home Health Care</p> <p>Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>The following services are not</p>	<p>Not Covered</p>

nature of your condition.
 Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Glossary; and
- provided on a part-time, intermittent schedule when Skilled Care is required. Refer to Glossary for the definition of Skilled Care.

We will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be “skilled” simply because there is not an available caregiver

Skilled care is skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- A physician orders them;
- They are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- They require clinical training in order to be delivered safely and effectively; and
- They are not Custodial Care.

covered:

- Custodial Care.
- Domiciliary care.
- Respite care.
- Rest cures.

Benefits are limited to **60** visits per calendar year. One visit equals four hours of skilled home health care services.

This visit limit does not include any service which is billed only for the administration of intravenous infusion.

<p>Custodial Care is defined as services that do not require special skills or training and that:</p> <ul style="list-style-type: none"> ● Provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating); ● Do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or ● Do not require continued administration by trained medical personnel in order to be delivered safely and effectively. 		
<p>Hospice Care</p> <p>Hospice Care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are only available when hospice care is received from a licensed hospice agency, which can include a Hospital.</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>Benefits are limited to 360 days during the entire period of time you are covered under the Policy.</p>	<p>Not Covered</p>
<p>Kidney Resource Services (KRS)</p>	<p>Kidney Resource Services provides access to top-performing dialysis centers and nurse consulting services to support the management of kidney diseases. Kidney transplantation candidates have access to the Transplant Centers of Excellence Network and Transplant Resource Services nurse consulting services.</p>	

	Please call a KRS nurse at 1-866-561-7518 for all inquiries and notifications. Information is also available at https://www.myoptumhealthcomplexmedical.com	
lasik surgery	50% of billed charges, limited to \$2,000 lifetime, combined in and out-of-network. The following services are not covered: Â· Photo Refractive Kerateomy (PRK) Â· Radial Keratotomy	50% of billed charges, limited to \$2,000 lifetime, combined in and out-of-network. The following services are not covered: Â· Photo Refractive Kerateomy (PRK) Â· Radial Keratotomy
Ostomy Supplies Benefits for ostomy supplies are limited to: <ul style="list-style-type: none"> • Pouches, face plates and belts. • Irrigation sleeves, bags and ostomy irrigation catheters. • Skin barriers. Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.	80% of eligible expenses after satisfying \$750 deductible.	Not Covered.
Pharmaceutical Products – Outpatient The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, or in a Covered Person's home. Examples of what would be included under this category include: <ul style="list-style-type: none"> • inhaled medication in an urgent care center for treatment of an asthma attack. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services - Sickness and Injury.	80% of eligible expenses after satisfying \$750 deductible.	Not Covered.

<p>Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional.</p> <p>Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy</p> <p>Benefits under this section do not include medications for the treatment of infertility</p>		
<p>Private Duty Nursing – Inpatient</p>	<p>Not Covered.</p> <p>The following service is not covered:</p> <ul style="list-style-type: none"> ● Private duty nursing 	<p>Not Covered.</p> <p>The following service is not covered:</p> <ul style="list-style-type: none"> ● Private duty nursing
<p>Prosthetic Devices</p> <p>Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:</p> <ul style="list-style-type: none"> ● artificial arms, legs, feet and hands; ● artificial face, eyes, ears and nose; ● breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, 	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered</p>

<p>including mastectomy bras and lymphedema stockings for the arm.</p> <p>Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses</p> <p>If more than 1 prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost</p> <p>Notification Required</p> <p>Please remember that for Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed \$1,000 in cost per device.</p> <p>If you don't obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses.</p>		
<p>Reconstructive Procedures</p> <p>Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated</p>	<p>Same as</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Surgery - Outpatient</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i> 	<p>Not Covered</p>

with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

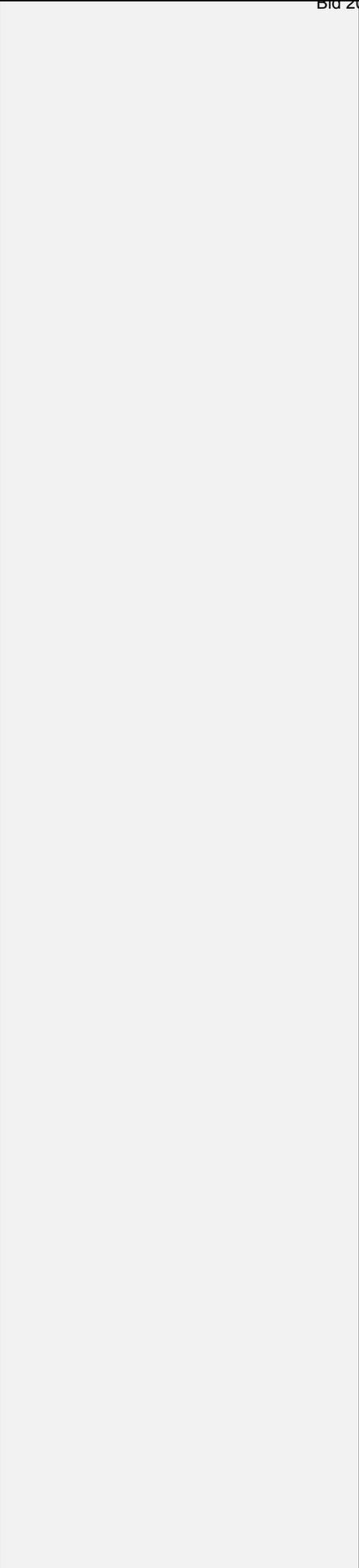
Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women’s Health and Cancer Rights Act of **1998**, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure

For Benefits you must notify us **5** business days before a scheduled reconstructive

You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy related services.



<p>procedure is performed. When you provide notification, we can determine whether the service is considered reconstructive or cosmetic. Cosmetic procedures are always excluded from coverage.</p> <p>In addition, for Non-Network Benefits you must notify us 24 hours before admission for an Inpatient Stay.</p> <p>If you don't notify us, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>Note: See exclusions described under <i>Physical Appearance</i>.</p>		
<p>Rehabilitation and Habilitative Services Outpatient Therapy and Manipulative Treatment</p> <p>Short-term outpatient rehabilitation services for:</p> <ul style="list-style-type: none"> • Physical therapy; • Occupational therapy; • Manipulative treatment • Speech therapy; • Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident; • Pulmonary rehabilitation therapy; and • Cardiac rehabilitation therapy. <p>For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.</p>	<p>\$50 copay per visit then 100% of eligible expenses.</p>	<p>Not Covered</p>

<p>The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant</p> <p>Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.</p> <p>Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.</p>		
<p>Shoe orthotics</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>Shoe orthotics are covered for diagnosis of Diabetes only.</p>	<p>Not Covered</p>
<p>Skilled Nursing Facility Inpatient Rehabilitation Facility Services</p> <p>Benefits include: Non-Physician services and supplies received during the Inpatient Stay; Room and board in a semi-private room (a room with two or more beds); and Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists.</p> <p>Benefits for other Physician services, are described under <i>Physician Fees for Surgical</i></p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>Benefits are limited to 60 days per calendar year.</p>	<p>Not Covered</p>

and Medical Services.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

<p>The following services are not covered:</p> <ul style="list-style-type: none"> • Custodial Care. • Domiciliary care. 		
<p>Sleep Disorders</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>Limited \$5,000 per lifetime.</p>	<p>Not Covered</p>
<p>Transplantation Services</p> <p>Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Provider and received at a Designated United Resource Networks Facility. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which benefits are available include but are not limited to:</p> <ul style="list-style-type: none"> • Heart; • Heart/lung; • Lung; • Kidney; • Kidney/pancreas; • Liver; • Liver/kidney; • Liver/intestinal; • Pancreas; • Intestinal; and • Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. <p>Benefits are also available for cornea transplants.</p>	<p>Voluntary</p> <p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>Travel and Lodging United Resource Networks will assist the patient and family with travel and lodging arrangements related to:</p> <ul style="list-style-type: none"> • Congenital Heart Disease (CHD); and • Transplantation services ; and <p>For travel and lodging services to be covered, the patient must be receiving services at a Designated United Resource Networks Facility.</p> <p>The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:</p> <ul style="list-style-type: none"> • Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up; • Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one 	<p>Voluntary</p> <p>Non-Network Benefits are not available.</p>

<p>Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.</p> <p>Pre-service Notification Requirement For Network Benefits you must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify us and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid.</p> <p>If you fail to notify us as required, Benefits will be reduced to 50% of Eligible Expenses.</p>	<p>companion. Benefits are paid at a per diem (per day) rate of up to \$50 per day for the patient or up to \$100 per day for the patient plus one companion; or</p> <ul style="list-style-type: none"> • If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to \$100 per day. <p>Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated United Resource Networks Facility (for Transplantation) or the CHD facility. The Company must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:</p> <ul style="list-style-type: none"> • Airfare at coach rate; • Taxi or ground transportation; or • Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated United Resource Networks Facility. <p>A combined overall maximum Benefit of \$10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all transplant procedures and CHD treatments during the entire period that person is covered under this Plan.</p>	
<p>Wigs</p>	<p>Not Covered</p>	<p>Not Covered</p>

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Alternative Treatments	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Acupressure ● Acupuncture ● Aromatherapy. ● Hypnotism. ● Massage Therapy. ● Roling. (holistic tissue massage); ● Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary 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 under <u><i>Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.</i></u> 	
Bereavement Counseling	80% of eligible expenses after satisfying \$750 deductible.	Not Covered
Breast Reconstruction	<p>Same as</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i> 	<p>Same as</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i>
Breast Reduction	Not Covered except as required by the Women's Health and Cancer Rights Act of 1998.	Not Covered except as required by the Women's Health and Cancer Rights Act of 1998.
Devices, Appliances and Prosthetics	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● devices used specifically as safety items or to affect performance in sports-related activities; ● orthotic appliances and devices that straighten or reshape a body part, except as described under <i>Durable Medical Equipment.</i> <p>Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over the counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.</p> <ul style="list-style-type: none"> ● cranial banding; ● the following items are excluded, even if prescribed by a 	

	<p>Physician:</p> <ul style="list-style-type: none"> • blood pressure cuff/monitor; • enuresis alarm; • non-wearable external defibrillator; • trusses; and • ultrasonic nebulizers; <ul style="list-style-type: none"> • the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect; • the replacement of lost or stolen prosthetic devices; • devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment; • oral appliances for snoring; <p>This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures.</p>
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<p>Diabetes Services</p> <p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.</p> <p>Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.</p> <p>Diabetes Self-Management Items</p> <p>Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is</p>	<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category.</p> <p>Diabetes Self-Management Items</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and <i>Prescription Drugs</i>.</p>	<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category.</p> <p>Diabetes Self-Management Items</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and <i>Prescription Drugs</i>.</p>
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<p>subject to all the conditions of coverage stated under <i>Durable Medical Equipment</i>. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the <i>Prescription Drugs</i>.</p> <p>Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under <i>Durable Medical Equipment</i>.</p> <p>Diabetic office visits waive the copay Diabetes related labs whether in the office or at a network lab will be covered at 100%, deductible does not apply. Out of network not covered.</p>		
<p>Dialysis</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>60% of eligible expenses after satisfying \$1,250 deductible.</p>
<p>Disposable Medical Supplies</p>	<p>Not Covered.</p>	<p>Not Covered.</p>
<p>Drugs</p>	<p>The following services are not covered under the medical portion of the plan:</p> <ul style="list-style-type: none"> ● Prescription drug for outpatient use that are filled by a prescription order or refill; ● self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting); ● Growth hormone therapy; ● Non-injectable medications given in a Physician's office except as required in an Emergency; and consumed in the Physician's office; and ● Over the counter drugs and treatments <p>See <i>Prescription Drug</i> section for a list of coverages.</p>	

Enteral Nutrition	Not Covered.	Not Covered.
Experimental or Investigational or Unproven Services	This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.	This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.
Foot Care Foot Orthotics - should be covered combined with DME	The following services are not covered: <ul style="list-style-type: none"> • Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under <i>Diabetes Services</i>. Routine foot care services that are not covered include: <ul style="list-style-type: none"> • Cutting or removal of corns and calluses; • Nail trimming or cutting; and • Debriding (removal of dead skin or underlying tissue); • Hygienic and preventive maintenance foot care. Examples include the following: <ul style="list-style-type: none"> • Cleaning and soaking the feet; • Applying skin creams in order to maintain skin tone; and • Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot; <p>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</p> <ul style="list-style-type: none"> • Treatment of flat feet; • Treatment of subluxation of the foot. 	
Gynecomastia	The following service is not covered: <ul style="list-style-type: none"> • Treatment of benign gynecomastia (abnormal breast enlargement in males.) 	
Medical Supplies	The following services are not covered: <ul style="list-style-type: none"> • Prescribed or non-prescribed medical and disposable supplies. Examples of supplies that are not covered include, but are not limited to: <ul style="list-style-type: none"> • elastic stockings, ace bandages, diabetic strips, and syringes; and • ostomy bags and related supplies; and • urinary catheters • tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment; and • the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect; and 	

	<ul style="list-style-type: none"> • the replacement of lost or stolen Durable Medical Equipment;and • deodorants, filters, lubricants, tape, appliance clears, adhesive, or adhesive remover or other items that are not specifically identified in <u><i>Ostomy Supplies</i></u>. <p>This exclusion does not apply to:</p> <ul style="list-style-type: none"> • disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under <u><i>Diabetes Services</i></u>; • diabetic supplies for which Benefits are provided as described under <u><i>Diabetes Services</i></u>; 	
Morbid Obesity	Not Covered.	Not Covered.
Nutrition and Health Education	<p>The following services are not covered:</p> <ul style="list-style-type: none"> • nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy; • nutritional counseling for either individuals or groups, except as defined under <u><i>Nutritional Counseling</i></u>; • Food of any kind. Foods that are not covered include: • enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition and unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; • foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; • oral vitamins and minerals; • meals you can order from a menu, for an additional charge, during an Inpatient Stay; and • other dietary and electrolyte supplements; and <p>Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.</p>	
Orthognathic Surgery	Not Covered.	Not Covered.
Personal Care, Comfort or Convenience	<p>The following services are not covered:</p> <p>Supplies, equipment and similar incidentals for personal comfort. Examples include:</p> <ul style="list-style-type: none"> • Television; • Telephone; • Beauty/barber service • Guest service; <p>Supplies, equipment and similar incidentals for personal comfort.</p>	

	<p>Examples include</p> <ul style="list-style-type: none"> ● Air conditioners; ● Guest service; ● Air purifiers and filters; ● Batteries and battery chargers; ● Dehumidifiers and humidifiers; ● Ergonomically correct chairs; ● Non-Hospital beds and comfort beds, motorized beds and mattresses; ● 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; ● Electric scooters; ● Exercise equipment and treadmills; ● hot tubs, Jacuzzis, saunas and whirlpools; ● medical alert systems; ● music devices; ● personal computers; ● pillows; ● power-operated vehicles; ● radios; ● strollers; ● safety equipment; ● vehicle modifications such as van lifts; ● video players; and ● Home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).
<p>Physical Appearance</p>	<p>The following services are not covered: Cosmetic Procedures are excluded. Examples include:</p> <ul style="list-style-type: none"> ● Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; ● Pharmacological regimens; ● Nutritional procedures or treatments; ● Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); ● hair removal or replacement by any means; ● treatments for skin wrinkles or any treatment to improve the appearance of the skin; ● treatment for spider veins; ● skin abrasion procedures performed as a treatment for acne; ● treatments for hair loss; ● varicose vein treatment of the lower extremities, when it is considered cosmetic; and ● Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure; ● Physical conditioning programs such as athletic training,

	<p>bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation;</p> <ul style="list-style-type: none"> • Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. • Non-surgical treatment of obesity..
<p>Procedures and Treatment</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> • biofeedback; • medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer).; • post-cochlear implant aural therapy • 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 but not limited to routine, long-term or maintenance/preventive treatment; • speech therapy to treat stuttering, stammering, or other articulation disorders • speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under Rehabilitation Services – Outpatient Therapy • a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy; • excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty); • psychosurgery (lobotomy); • • chelation therapy, except to treat heavy metal poisoning; • Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies; • 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; • sex transformation operations; • non-surgical treatment, even if for morbid obesity; and • surgical treatment of obesity even if there is a diagnosis of morbid obesity; • Medical and surgical treatment of hyperhidrosis (excessive sweating); and • the following Services for the evaluation and treatment of

	<p>temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances, surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations;</p> <ul style="list-style-type: none"> • upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment, except as treatment of obstructive sleep apnea; and • breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures; 	
<p>Providers</p>	<p>The following services are not covered: Services:</p> <ul style="list-style-type: none"> • Performed by a Provider who is a family member by birth or marriage, including your spouse, brother, sister, parent or child; • A provider may perform on himself or herself; • Performed by a provider with your same legal residence; • Services ordered or delivered by a Christian Science practitioner; • Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license; • Provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider; • Which are self-directed to a free-standing or Hospital-based diagnostic facility; and • Ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care: <ul style="list-style-type: none"> • Prior to ordering the service; or • After the service is received. <p>This exclusion does not apply to mammography testing.</p>	
<p>Radiation Therapy</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p>	<p>Not Covered.</p>
<p>Services Provided Under Another Plan</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> • Services for which coverage is available: <ul style="list-style-type: none"> • Under another plan, except for Eligible Expenses payable as described under <i>Coordination of Benefits</i>; • Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you; • While on active military duty; and • For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible. 	

<p>Smoking Cessation</p> <p>Limited to \$500 per calendar year and \$1,000 per lifetime - includes coverage for drugs and related office visits.</p>	<p>80% of eligible expenses after satisfying \$750 deductible.</p> <p>At Office: \$20 Primary Physician/ \$50 Specialist copay per visit then 100% of eligible expenses.</p>	<p>Not Covered.</p>
<p>Temporomandibular Joint (TMJ) Services</p> <p>The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.</p> <p>Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections</p> <p>Benefits are provided for surgical treatment if:</p> <ul style="list-style-type: none"> ● there is clearly demonstrated radiographic evidence of significant joint abnormality; ● non-surgical treatment has failed to adequately resolve the symptoms; and ● pain or dysfunction is moderate or severe. <p>Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include FDA-approved TMJ implants only when all other treatment has failed.</p>	<p>Same as</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Surgery - Outpatient</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i> <p>limited to \$5,000 per lifetime. Coverage is available for the evaluation and treatment of temporomandibular joint syndrome (TMJ), including surgery.</p> <p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances, surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations. 	<p>Not Covered.</p>

<p>Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described under <u><i>Hospital – Inpatient Stay</i></u> and <u><i>Physician Fees for Surgical and Medical Services</i></u>, respectively.</p>		
<p>Travel</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Health services provided in a foreign country , unless required as Emergency Health Services; ● Travel or transportation expenses, even if ordered by a Physician, except as identified under <i>Travel and Lodging</i>. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan’s discretion. 	
<p>Types of Care</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Custodial Care or maintenance care; ● Domiciliary Care; ● multi-disciplinary pain management programs provided on an inpatient basis; ● 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 described under Hospice Care; ● rest cures; ● services of personal care attendants; and ● Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work). 	
<p>Vision and Hearing</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● routine vision exam, including refractive examinations to determine the need for vision correction; ● Purchase cost and associated fitting charges for eyeglasses or contact lenses; ● implantable lenses used only to correct a refractive error (such as Intacs corneal implants); ● bone anchored hearing aids except when either of the following applies: <ul style="list-style-type: none"> ● for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a 	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● routine vision exam, including refractive examinations to determine the need for vision correction; ● Purchase cost and associated fitting charges for eyeglasses or contact lenses; ● implantable lenses used only to correct a refractive error (such as Intacs corneal implants); ● purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices; ● Eye exercise or vision

	<p>wearable hearing aid; or</p> <ul style="list-style-type: none"> ● for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid and ● Eye exercise or vision therapy; ● Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy. <p>Please refer to <i>Vision Care</i> section for a description of covered services for vision.</p>	<p>therapy;</p> <ul style="list-style-type: none"> ● Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy. <p>Please refer to <i>Vision Care</i> section for a description of covered services for vision.</p>
<p>Wisdom Teeth</p>	<p>Not Covered.</p>	<p>Not Covered.</p>
<p>All Other Exclusions</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Autopsies and other coroner services and transportation services for a corpse; ● Charges for: <ul style="list-style-type: none"> ● Missed appointments; ● Room or facility reservations; ● Completion of claim forms; or ● Record processing; ● Charges prohibited by federal anti-kickback or self-referral statutes; ● Diagnostic tests that are: <ul style="list-style-type: none"> ● Delivered in other than a Physician’s office or health care facility; and ● Self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests; ● Expenses for health services and supplies: <ul style="list-style-type: none"> ● That do not meet the definition of a Covered Health Service; ● That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force 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 a non-war zone; ● That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends; 	

	<ul style="list-style-type: none"> ● 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 this benefit Plan; ● That exceed Eligible Expenses or any specified limitation; ● For which a Provider waives the Copay, Deductible or Coinsurance amounts; ● foreign language and sign language services; ● Long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; ● Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatment when: <ul style="list-style-type: none"> ● Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; ● Conducted for purposes of medical research; ● Related to judicial or administrative proceedings or orders; or ● Required to obtain a license of any type.
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PRESCRIPTION DRUGS

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Pharmacy Benefit Manager (PBM)	<p>OptumRx</p>  For all pharmacy support, please refer to the telephone number on the back of your ID card.	
<p>Prescription Drug Definition</p> <p>A medication, product or device that has been approved by the Food and Drug Administration and that can only be legally dispensed using a prescription order or refill. A Prescription Drug is appropriate for self-administration or administration by a non-skilled caregiver.</p>	<p>Benefits are available for Prescription Drugs at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug is listed.</p> <p>Benefits for Prescription Drugs are available when the Prescription Drug meets the definition of a Covered Health Service.</p>	
Step Therapy	<p>Certain Prescription Drugs for which Benefits are described in this section or Pharmaceutical Products for which Benefits are described under your medical Benefits are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drugs or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Product(s) first.</p>	

	You may determine whether a particular Prescription Drug or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling the telephone number on your ID card.	
What You Must Pay	You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.	
Annual Drug Deductible	Network and Non-Network No Annual Drug Deductible.	
Out-of-Pocket Drug Maximum	See Out-of-Pocket Maximum (OOPM) -under this pharmacy coverage plan, the deductible & out-of-pocket maximum include both medical and pharmacy expenses.	
Infertility Maximum Policy Benefit	Not Applicable	
Retail Purchases Notification Requirements Before certain prescription drugs are dispensed to you, it is the responsibility of your physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the prescription drug is: <ul style="list-style-type: none"> ● A Covered Health Service as defined by the Plan; and ● Not Experimental and Investigational or Unproven. If UnitedHealthcare is not notified before the prescription drug is dispensed, you may pay more for that prescription drug order or refill. You will be required to pay for the prescription drug at the time of purchase. To determine if a prescription drug requires notification, either	Coverage up to 31-day supply. <ul style="list-style-type: none"> ● Tier 1: \$10 copay then 100% of eligible expenses. ● Tier 2: \$25 copay then 100% of eligible expenses. ● Tier 3: \$50 copay then 100% of eligible expenses. Note: Tier 1 was previously referred to as Generic, Tier 2 was previously referred to as Preferred Brands and Tier 3 was previously referred to as Non-Preferred drugs or Brand Name Drugs that are not included on the Prescription Drug List.	Not Covered

<p>visit myuhc.com or call the toll-free number on your ID card. The prescription drugs requiring notification are subject to UnitedHealthcare's periodic review and modification.</p>		
<p>Mail Order Purchases</p>	<p>Coverage up to 90-day supply</p> <ul style="list-style-type: none"> ● Tier 1: \$25 copay then 100% of eligible expenses. ● Tier 2: \$50 copay then 100% of eligible expenses. ● Tier 3: \$50 copay then 100% of eligible expenses. <p>Note: Tier 1 was previously referred to as Generic, Tier 2 was previously referred to as Preferred Brands and Tier 3 was previously referred to as Non-Preferred drugs or Brand Name Drugs that are not included on the Prescription Drug List.</p>	<p>Not Covered</p>
<p>Health Care Reform Preventive Care Medications</p>	<p>Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined below.</p> <p>Health Care Reform Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:</p> <ul style="list-style-type: none"> ● Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. ● With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. ● With respect to women, such additional preventive care and 	

	<p>screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.</p> <p>You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling the telephone number on your ID card.</p>
<p>Specialty Pharmacy Program</p> <p>Self- administered Diabetes products DO NOT fall into this category</p>	<p>Not Applicable – Has not opted into the Specialty Pharmacy Program</p>

CSR View

<p>Situation</p>	<p>2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK</p>	<p>2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK</p>
<p>OptumRx</p> <p>Refer to VCC Desktop for all telephone numbers.</p>	<p>Fresh Start Customer</p> <p><u>General Commercial Pharmacy Help Desk (Public Line)</u> Designed to assist with Pharmacy inquiries, can also assist with compound drug verification, emergency refills, vacation overrides (emergency refills and vacation overrides are initiated by the pharmacy)</p> <p><u>Prior Authorization Department</u> Press 1 for standard oral medications Press 2 for Specialty Drugs This number may be disclosed to the member, ensure that they have their physician contact this number directly for immediate assistance. Many prior authorizations can be completed in real time.</p> <p><u>OptumRx Mail Service Member Line</u> This is the standard OptumRx Mail Order Dept, where the member will initially be taken into an automated system. If the member is new to mail order they can select the appropriate prompt. The Mail Service Dept can also provide general assistance with the OptumRx member website. In the event the member needs additional assistance, they will connect our members with a tech representative.</p> <p><u>Specialty Pharmacy Patient Care Coordinator Line</u> <i>Prescriber/Member New Prescription or New Services</i> When a member is transferred to this number, they will receive assistance with their drug questions, coverage verification, prior auth if needed, and setting up an account for ordering.</p> <p><u>Specialty Pharmacy Patient Care Coordinator Line</u></p>	

	<p align="center">Prescriber/Member Refill Prescription on Existing Services</p> <p>Member can contact this number to refill their specialty medication. Please be aware that this number is for REFILL only.</p> <p><u>Doctor to Registered Pharmacist Line</u></p> <p>This line should only be used by doctors or their authorized staff who are calling in new prescriptions or refills to be used at Mail Service.</p> <p>BPL Number: 62564</p>
<p>Specialty Pharmacy Program Quick Tip</p>	<ul style="list-style-type: none"> The UnitedHealthcare Specialty Pharmacy Program applies to pharmacy benefits only. Reference the Customer Service drug list available on PharWeb (<i>access through customer service SOP</i>) to verify specialty medications subject to this program. This program DOES NOT determine benefit coverage - this program only supports obtaining medications from a specific provider. <p>Exceptions: Lock out codes</p> <p>ASO clients who have opted into the Specialty Pharmacy Program can choose to opt out of certain therapeutic classes. The following opt outs exist and should be reflected in the Specialty Pharmacy Program section above – specifically the therapeutic class should be removed from the list and there should be a call out that that particular therapeutic class has been excluded from the program. A client can only opt out of one of the options below. This will be a very rare occurrence.</p> <ul style="list-style-type: none"> Hemophilia – will be addressed in Hemophilia Program section HIV/Aids & Transplant (<i>exclusion will be for both classes if client has chosen this opt out</i>) Oral Oncology

OTHER BENEFITS

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN
Dental Vendor	Administrator: UnitedHealthcare Dental Phone Number: 1-877-816-3596
Discount Program	Health Discount Program, offered through UnitedHealth Allies Call 1-800-860-8773 Accessed via myuhc.com or www.unitedhealthallies.com
Health & Wellness	Optum Health & Wellness Online resources Access resources online at www.myuhc.com

	<p>For Online content and technical questions call 1-866-868-5484.</p>
<p>hi HealthInnovations™ Hearing Program</p>	<p>Hearing loss can affect your life in many ways. It can cause anxiety, depression, isolation and frustration. There is help. Through <i>hi HealthInnovations</i> and your medical plan administered by UnitedHealthcare, you can get customized hearing aids for a fraction of the cost you would have paid at other retailers.</p> <p>Through <i>hi HealthInnovations™</i> members can pay a discounted rate for high-quality, custom-programmed hearing aids, starting at \$479 each, saving them thousands of dollars in out-of-pocket-costs. There is no cost to members to access this program to take advantage of special member pricing</p> <p>Three steps to better hearing</p> <p>1. Ask your health care provider for a hearing test Your medical plan pays for a hearing test if recommended by a physician. If you've already been tested within the past year, fax your results to 1-877-955-4336 to receive hearing aid recommendations. Go to www.hiHealthInnovations.com/united for more information.</p> <p>2. Choose your hearing aid Based on your hearing test results, select from recommended hearing aids that are programmed specifically for you and delivered right to your door.</p> <p>Each hearing aid comes with:</p> <ul style="list-style-type: none"> • FREE batteries and ear tubes/wax guards that will last most users six months • 45-day no-risk trial period • One-year manufacturer's warranty <p>3. Place your order Get started on the path to better hearing today! Log on to www.hiHealthInnovations.com/united to check out what hearing aid would be best for you and see your low member pricing.</p> <p>You can also call 1-866-926-6632, 8a.m. to 6p.m. CT, Monday through Friday to place an order or to get more information.</p>
<p>Incentives for Health</p>	<p>NOT APPLICABLE</p>
<p>Simply Engaged Wellness Incentive Program</p>	<p>NOT APPLICABLE</p>
<p>Vision Vendor</p>	<p>Administered by: UnitedHealthcare Vision</p> <ul style="list-style-type: none"> • Call 1-800-638-3120

Please contact **UnitedHealthcare Vision** to verify eligibility and coverage for routine vision.

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Carve Out Disease Management Program	Not Applicable	
Diabetes Prevention and Control Alliance (DPCA)	Diabetes Prevention and Control Alliance is an OUTBOUND program and participants are directed based on claims data analysis, health screenings and physician referrals. If the participant has lost the mailing and/or information to Diabetes Prevention and Control Alliance available at external participating vendors such as the local YMCAs and/or local pharmacies, please REFER the caller to 1-888-688-4019.	

MENTAL HEALTH

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Vendor	Administered by: United Behavioral Health –Health Plan Division <ul style="list-style-type: none"> ● Call: 1-800-842-5724 EAP <ul style="list-style-type: none"> ● Does Not Apply 	Administered by: United Behavioral Health –Health Plan Division <ul style="list-style-type: none"> ● Call: 1-800-842-5724 EAP <ul style="list-style-type: none"> ● Does Not Apply
Mental Health Services Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider’s office or at an Alternate Facility. Benefits include the following services provided on either an outpatient or inpatient basis: <ul style="list-style-type: none"> ● diagnostic evaluations 	Services received on an inpatient basis in a Hospital or Alternate Facility: 80% of eligible expenses after satisfying the \$750 deductible. Services received on an outpatient basis in a provider’s office or at an Alternate Facility: \$50 per individual visit. \$45 per group visit.	Services received on an inpatient basis in a Hospital or Alternate Facility: 60% of eligible expenses after satisfying \$1,250 deductible. Services received on an outpatient basis in a provider’s office or at an Alternate Facility: 60% of eligible expenses after satisfying \$1,250 deductible.

<p>and assessment;</p> <ul style="list-style-type: none"> ● treatment planning; ● referral services; ● medication management; ● individual, family, therapeutic group and provider-based case management services; and ● crisis intervention. <p>Benefits include the following services provided on an inpatient basis:</p> <ul style="list-style-type: none"> ● Partial Hospitalization/Day Treatment; ● services at a Residential Treatment Facility; <p>Benefits include the following services provided on an outpatient basis:</p> <ul style="list-style-type: none"> ● Intensive Outpatient Treatment; <p>The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p> <p>You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.</p> <p>Special Mental Health Programs and Services Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services benefit.</p> <p>The Mental Health Services Benefits and financial requirements assigned to these programs or services are based</p>	<p>You are not required to provide pre-service notification when you seek these services from Network providers. Network providers are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.</p> <p>Network provider ONLY will be responsible for obtaining the following notification requirements:</p> <ul style="list-style-type: none"> ● Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management <p>For a scheduled admission, Network provider must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, Network provider must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with 	<p>Notification Required You must provide pre-service notification as described below.</p> <p>When Benefits are provided for any of the services listed below, the following services require notification:</p> <ul style="list-style-type: none"> ● Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. <p>For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. <p>If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to 50%</p>
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<p>on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use.</p> <p>Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.</p>	<p>or without medication management</p>	<p>of Eligible Expenses</p>
<p>Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</p> <p>The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:</p> <ul style="list-style-type: none"> • Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and • Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning. <p>These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of</p>	<p>Services received on an inpatient basis in a Hospital or Alternate Facility:</p> <p>75% of eligible expenses after satisfying the \$750 deductible</p> <p>Services received on an outpatient basis in a provider's office or at an Alternate Facility:</p> <p>\$50 per individual visit.</p> <p>\$45 per group visit.</p> <p>You are not required to provide pre-service notification when you seek these services from Network providers. Network providers are responsible for notifying the Mental Health/Substance Use Disorder Administrator</p>	<p>Services received on an inpatient basis in a Hospital or Alternate Facility:</p> <p>60% of eligible expenses after satisfying \$1,250 deductible.</p> <p>Services received on an outpatient basis in a provider's office or at an Alternate Facility:</p> <p>60% of eligible expenses after satisfying \$1,250 deductible.</p> <p>Notification Required You must provide pre-service notification as described below.</p> <p>When Benefits are provided for any of the services listed below, the following services require notification:</p> <ul style="list-style-type: none"> • Neurobiological Disorders - Mental Health Services for

<p>Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories covered by the plan.</p> <p>Benefits include the following services provided on either an outpatient or inpatient basis:</p> <ul style="list-style-type: none"> ● diagnostic evaluations and assessment; ● treatment planning; ● referral services; ● medication management; ● individual, family, therapeutic group and provider-based case management services; and ● crisis intervention <p>Benefits include the following services provided on an inpatient basis:</p> <ul style="list-style-type: none"> ● Partial Hospitalization/Day Treatment ● services at a Residential Treatment Facility. <p>Benefits include the following services provided on an outpatient basis:</p> <ul style="list-style-type: none"> ● Intensive Outpatient Treatment. <p>The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p> <p>You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.</p>	<p>before they provide these services to you.</p> <p>Network provider ONLY will be responsible for obtaining the following notification requirements:</p> <ul style="list-style-type: none"> ● Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorder - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. <p>For a scheduled admission, Network provider must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, Network provider must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management 	<p>Autism Spectrum Disorder - inpatient services (including partial hospitalization/day treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.</p> <p>For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. <p>If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to 50% of Eligible Expenses</p>
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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Inpatient Coinsurance apply to Out-of-pocket	Yes	Yes
Outpatient Coinsurance apply to Out-of-pocket	Not Applicable	Yes

SUBSTANCE ABUSE

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Vendor	Administered by: United Behavioral Health-HealthPlan Division <ul style="list-style-type: none"> • Call: 1-800-842-5724 EAP <ul style="list-style-type: none"> • Does Not Apply 	Administered by: United Behavioral Health-HealthPlan Division <ul style="list-style-type: none"> • Call: 1-800-842-5724 EAP <ul style="list-style-type: none"> • Does Not Apply
Substance Use Disorder Services Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits include the following services provided on either an inpatient or outpatient basis: <ul style="list-style-type: none"> • diagnostic evaluations and assessment; • treatment planning; • referral services; • medication management; • individual, family, therapeutic group and 	Services received on an inpatient basis in a Hospital or Alternate Facility: 80% of eligible expenses after satisfying the \$750 deductible Services received on an outpatient basis in a provider's office or at an Alternate Facility: \$50 per individual visit. \$45 per group visit. You are not required to provide pre-service notification when you seek these services from Network providers. Network providers	Services received on an inpatient basis in a Hospital or Alternate Facility: 60% of eligible expenses after satisfying \$1,250 deductible. Services received on an outpatient basis in a provider's office or at an Alternate Facility: 60% of eligible expenses after satisfying \$1,250 deductible. Notification Required You must provide pre-service notification as described below. When Benefits are provided for any of the services listed below, the following services require notification: <ul style="list-style-type: none"> • Substance Use Disorder

<p>provider-based case management;</p> <ul style="list-style-type: none"> ● crisis intervention. ● detoxification (sub-acute/non-medical); <p>Benefits include the following services provided on an inpatient basis:</p> <ul style="list-style-type: none"> ● Partial Hospitalization/Day Treatment; ● services at a Residential Treatment Facility; <p>Benefits include the following services provided on an outpatient basis:</p> <ul style="list-style-type: none"> ● Intensive Outpatient Treatment; <p>The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p> <p>You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.</p> <p>Special Substance Use Disorder Programs and Services</p> <p>Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit.</p> <p>The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient,</p>	<p>are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.</p> <p>Network provider ONLY will be responsible for obtaining the following notification requirements:</p> <ul style="list-style-type: none"> ● Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management <p>For a scheduled admission, Network provider must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, Network provider must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management 	<p>Services - inpatient services (including partial hospitalization/day treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management.</p> <p>For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. <p>If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.</p>
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<p>Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use.</p> <p>Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.</p>		
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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
<p>Mental Health and Substance Use Disorder Services</p>	<p>Exclusions listed directly below apply to services described under <i>Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders and/or Substance Use Disorders</i></p> <p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Services performed in connection with conditions not classified in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i>; ● services or supplies for the diagnosis or treatment of Mental Illness , alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: <ul style="list-style-type: none"> ● not consistent with generally accepted standards of medical practice for the treatment of such conditions; ● not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; ● not consistent with the Mental Health/Substance Use Disorder Administrator’s level of care guidelines or best practices as modified from time to time; or 	

	<ul style="list-style-type: none"> ● not clinically appropriate for the patient’s mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. ● Mental Health Services as treatments for V-code conditions as listed within the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i>; ● Mental Health Services as treatment for a primary diagnosis of insomnia, other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis; ● Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and, paraphilias (sexual behavior that is considered deviant or abnormal); ● educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; ● tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act; ● learning, motor skills and primary communication disorders as defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i>; ● mental retardation as a primary diagnosis defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i>; ● methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction; ● intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders; ● 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. 	
<p>Inpatient Coinsurance apply to Out-of-pocket</p>	<p>Yes</p>	<p>Yes</p>
<p>Outpatient Coinsurance apply to Out-of-pocket</p>	<p>Not Applicable</p>	<p>Yes</p>

ATTACHMENT H – POLICY DATA - ADVANTAGE PLUS PLAN

Policy Holder Name	Collin County
Medical Policy Number	229670
Set Number	006ACIS
Effective Date	01/01/2014
Cancellation Date	99/99/9999
iBAAG Document Author	Praneeth Chary. N
Revision Reason	Plan Change

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN
Health Care Reform	<p><u>Summary of Benefits and Coverage (SBC)</u> <i>SBC Creation</i> Responsible Party: UHC</p> <p><i>Member Fulfillment</i> Responsible Party: Customer</p> <p><i>External Vendor (Carve-out)</i> Are external vendor benefits included in SBC? Pharmacy benefits - No Mental Health benefits - No</p> <p><u>Expanded Women’s Preventive Care Services Apply?</u> Yes</p> <p>Coverage guidelines for Expanded Women’s Preventive Care include:</p> <ul style="list-style-type: none"> • Breast-feeding support, supplies, and counseling. Click <u>here</u> for Network breast pump providers • Contraception methods and counseling • Domestic violence screening • Gestational diabetes screening • HIV screening and counseling • Human papillomavirus testing (beginning at age 30, and for every 3 years thereafter) • Sexually transmitted infections counseling • Well-woman visits <p>Click <u>here</u> for additional information on eligible services covered under the Expanded Women’s Preventive Care Services.</p>
Acquisition Integration Business Information	Acquisition/Integration applies? No

Business Segment	KEY ACCOUNTS
COSMOS To UNET Converted Case	Not Applicable
Product Year	2007
State of Issue	Texas
ERISA	No
Final Claim Fiduciary	<ul style="list-style-type: none"> • Urgent Care: UHC • 1st Level Pre-Service: UHC • 2nd Level Pre-Service: UHC • 1st Level Post-Service: UHC • 2nd Level Post-Service: UHC <ul style="list-style-type: none"> • Urgent /Escalated Appeals - All agents follow your current Urgent Appeals Guidelines. • Pre-Service - Submit written appeal to the P.O. Box address on the initial determination letter or UnitedHealthcare, P.O. Box 30432, Salt Lake City, Utah 84130-0432 • Post-Service - Submit written appeal as directed on the EOB or UnitedHealthcare, P.O. Box 30432, Salt Lake City, Utah 84130-0432 <p>The regulation requires that appeals be addressed in the following timeframes based on appeal type:</p> <ul style="list-style-type: none"> • Urgent appeals - 72 hours • Pre-service requests - 15 calendar days • Post service claims - 30 calendar days
COBRA Information	Administrator: United Healthcare Benefit Services Phone Number: 1-866-747-0048. Individual Medical Conversions allowed: No NOTE: For more information on Individual Medical Conversions please consult section 3.3 within CDS.
Coordination of Benefits COB	Other Insurance: Non-Duplication For secondary COB situations, does this customer follow the NAIC guideline to cover all non-covered benefits allowed by the primary carrier? Yes

	Medicare: Non-Duplication (Med 5)
Claim Filing Limit	You must submit a request for payment of Benefits within 1 year after the date of service. If you don't provide this information to us within 1 year of the date of service, Benefits for that health service will be denied or reduced, in our or the Claims Administrator's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends. With respect to this claim filing limit, "you" refers to the member.
Covered Health Services	Covered Health Services are defined as those health services and supplies that are: <ul style="list-style-type: none"> • Provided for the purpose of preventing, diagnosing or treating Sickness, Injury, mental illness, substance use or their symptoms; • Provided to a person who meets the Plan's eligibility requirements; and • Not identified as excluded.
Dependent Definition	<p>An eligible Dependent includes:</p> <ul style="list-style-type: none"> • The Participant's Spouse. • Any Dependent child under 26 years of age, including a natural child, a stepchild, a legally adopted child and a child for whom you or your Spouse are the legal guardian. • Coverage for Dependents terminates at the end of the month in which the child attains the maximum age. <p>Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.</p> <p>A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.</p> <p>To be eligible for coverage under the Policy, a Dependent must reside within the United States.</p>
Dependent Maternity Coverage	Yes

<p>Coverage for a Disabled Dependent Child</p>	<p>Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:</p> <ul style="list-style-type: none"> • Is not able to be self-supporting because of mental or physical handicap or disability. • Depends mainly on the Subscriber for support. <p>Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.</p> <p>We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.</p> <p>We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.</p> <p>If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.</p>
<p>Extended Coverage for Total Disability</p> <p>Total Disability or Totally Disabled - a Employees inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.</p>	<p>Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:</p> <ul style="list-style-type: none"> • The Total Disability ends. • 3 months from the date coverage would have ended when the entire Policy was terminated.
<p>Eligibility Contact</p>	<p>UHC</p>
<p>Facility Reasonable Customary</p>	<p>Yes</p> <ul style="list-style-type: none"> • Outpatient \$500 • Inpatient \$10,000

Foreign-International Claims	Health services provided in a foreign country are not eligible, unless required as Emergency Health Services.
Funding Arrangement	ASO
HIPAA	UHC sends out certificates of credible coverage.
Human Resource Contact	Contact: Collin County Phone Number: (972) 548-4605
Integrated Medical and Disability Support Program	Not Applicable
Care Coordination/C2	Not Applicable
Care Coordination	All Care Coordination sites are area code routed.
UnitedHealthcare Personal Health Support	Not Applicable
Medicare Crossover	Group is eligible for Medicare Crossover: No
Are Pre-existing Conditions covered?	Yes
R&C Tolerance Level	\$5 Medical/\$25 Surgical
Run In	Not Applicable
Shared Savings	Yes
Transition of Care – Pregnancy	2nd and 3rd trimester covered.

DEDUCTIBLES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
<p>Annual Deductible</p> <p><i>Definition of Annual Deductible</i> The Annual Deductible is the amount of eligible expenses you must pay each calendar year for Covered Health Services before the Plan begins paying for Eligible Expenses.</p> <p>The deductible applies to the service(s) where it is specifically identified in the sections below.</p>	<p>\$250 per Covered Person per calendar year, not to exceed \$500 for all Covered Persons in a family.</p>	<p>\$500 per Covered Person per calendar year, not to exceed \$1,000 for all Covered Persons in a family.</p>
<p>Per Occurrence Deductible</p> <ul style="list-style-type: none"> • 	<p>Network No Per Occurrence Deductible.</p>	<p>Non-Network No Per Occurrence Deductible.</p>

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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Deductible Cross Apply	No	No
Last Quarter Carry Over	No	No
<p>Limited Services Counting Method</p> <p>Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that</p>	Benefits which apply visit limitations will apply on the 1st claim.	

maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.	
Prorated Deductible and Out-of-Pocket	Does Proration apply? No

OUT OF POCKET

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
<p>Out-of-Pocket Maximum (OOPM)</p> <p>The Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services.</p> <p>If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.</p>	<p>\$2,000 per Covered Person per calendar year, not to exceed \$4,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Maximum does include the Annual Deductible.</p> <p>The following costs will never apply to the Out-of-Pocket Maximum:</p> <ul style="list-style-type: none"> • Any charges for non-Covered Health Services. • The amount of any reduced Benefits if you don't notify us as described in the section titled <i>Notification Requirements</i>. 	<p>No Out-of-Pocket Maximum</p>
<p>Out of Network Benefits</p>	<p>When Covered Health Services are received from non-Network providers, Eligible Expenses are determined based on either:</p> <p style="text-align: center;">Fee(s) that are negotiated with the provider.</p> <p style="text-align: center;">Available data resources of competitive fees in that geographic area.</p> <p>NOTE: If care is received from a non-network physician, facility, or other health care professional you will incur greater financial expense compared to an in-network provider. Your plan only pays a portion of those charges and it is your responsibility to</p>	

	pay the remainder. You are required to pay the amount that exceeds the allowable amount, which could be significant, and that amount does not apply to the Out-of-Pocket Maximum. We recommend you ask the non-network physician or health care professional about their billed charges before you receive care.	
Maximum Plan Benefit There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this plan. Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.	No Maximum Plan Benefit	No Maximum Plan Benefit
Annual Maximum Benefit	No Annual Maximum Benefit.	

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Do deductibles apply to out-of-pocket?	Yes	NO
Does the Per Occurrence Deductible apply to out-of-pocket?	Not Applicable	Not Applicable

Out-of-pocket Cross Apply	No	No
Inpatient confinement deductible applies to out-of-pocket	Not Applicable	Not Applicable
Copay emergency room apply to out-of-pocket	Yes	No
Copay office apply to out-of-pocket	Yes	Not Applicable
Copay Premium Designated office apply to out-of-pocket	Not Applicable	Not Applicable
Copay hospital apply to out-of-pocket	Yes	Not Applicable
Copay Premium Designated hospital apply to out-of-pocket	Not Applicable	Not Applicable
Copay outpatient surgical facility apply to out-of-pocket	Not Applicable	Not Applicable
Copay urgent care center services apply to out-of-pocket	Yes	Not Applicable
Coinsurance apply to out of pocket	Yes	Yes
Out of Network Benefits	Not Applicable	80th percentile of R&C
Extended Non-Network Reimbursement Program (ENRP)	No	

COINSURANCE

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Patient Protection and Affordable Care Act (PPACA)	Patient Protection Notices The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family	

	<p>members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.</p> <p>For children, you may designate a pediatrician as the primary care provider.</p> <p>You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.</p>	
<p>Coinsurance</p> <p>The percentage of Eligible Expenses payable by the plan for certain Covered Health Services after you meet the annual deductible.</p>	<p>In-Network Plan Level Coinsurance- 75% of eligible expenses after satisfying \$250 deductible until Out-of-Pocket is reached.</p>	<p>Out-of-Network Plan Level Coinsurance- 60% of eligible expenses after satisfying \$500 deductible until Out-of-Pocket is reached.</p>
<p>Copayment</p>	<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services.</p> <p>Please note that for each designated covered benefit category, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> ● The applicable Copayment. ● The Eligible Expense. <p>When Copayments apply, please refer to specific benefit category for the reimbursement policy.</p> <p>Details about the way in which Eligible Expenses are determined appear in the benefit category of <i>Eligible Expenses</i> further below.</p>	
<p>Eligible Expenses</p> <p>Eligible Expenses are the amount we determine that we will pay for Benefits.</p> <p>Definition of an Eligible Expense:</p>	<p>For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the</p>	<p>For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.</p>

<p>For Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below.</p> <p>Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:</p> <ul style="list-style-type: none"> As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS). As reported by generally recognized professionals or publications. As used for Medicare. As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept. 	<p>Summary Plan Description.</p> <p>If one or more alternative health services that meets the definition of Covered Health Service in the benefit categories of Mental Health and Substance Use Disorder are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, Substance Use Disorder or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.</p> <p>For Network Benefits, Eligible Expenses are based on either of the following:</p> <ul style="list-style-type: none"> When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider. When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated. 	<p>When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, at our discretion, based on the lesser of:</p> <ul style="list-style-type: none"> For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area. When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 100% of the amount that the Centers for Medicare and Medicaid Services (CMS) would have paid under the Medicare program for the drug determined by either of the following: Reference to available CMS schedules. Methods similar to those used by CMS. Fee(s) that are negotiated with the provider. 50% of the billed charge. A fee schedule that we develop.
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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
None		
None		

FLEXIBLE SPENDING ACCOUNT

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN
FSA Vendor	<ul style="list-style-type: none"> • Administered by: UnitedHealthcare • Call 1-800-331-0480 <p>Does the Limited Purpose Flexible Spending Account apply? No</p>
Retiree Reimbursement Account (RRA)	Not Applicable
UnitedHealthcare Consumer Accounts Card	No

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
None		
None		

HOSPITAL SERVICES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Accessing Benefits	<p>You can choose to receive Network Benefits or Non-Network Benefits.</p> <p>Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as Network Benefits.</p> <p>Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network</p>	

	<p>provider, or Covered Health Services that are provided at a non-Network facility.</p> <p>You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.</p> <p>Health Services from Non-Network Providers Paid as Network Benefits</p> <p>If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.</p>	
<p>Notification Requirements</p> <p>Special Note Regarding Medicare</p> <p>If you are enrolled in Medicare and Medicare pays benefits before the Plan, you are not required to notify us before receiving Covered Health Services.</p>	<p>Prior notification is required before you receive certain Covered Health Services.</p> <p>You are responsible for notifying us before you receive the following Covered Health Services:</p> <ul style="list-style-type: none"> • Clinical Trials • Dental Services -Accident Only • Emergency Health Services if you are admitted to a non-Network Hospital. • Reconstructive Procedures • As soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). <p>Please refer to the Mental Health and Substance Use Disorder section for notification requirements pertaining to Mental Health and Substance Use Disorder treatment.</p> <p>**REFER TO SPECIFIC BENEFIT SECTION FOR APPLICABLE PENALTIES FOR NOTIFICATION</p>	<p>Prior notification is required before you receive certain Covered Health Services.</p> <p>You are responsible for notifying us before you receive the following Covered Health Services:</p> <ul style="list-style-type: none"> • Clinical Trials • Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery; • Skilled Nursing Facility/ Inpatient Rehabilitation Facility • Hospital-Inpatient Stay including Emergency admission • Temporomandibular Joint Services • As soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). • As soon as Congenital Heart Disease is suspected or diagnosed (in utero detection, at birth, or as determined and before the

		<p>time an evaluation for CHD is performed).</p> <ul style="list-style-type: none"> You must notify us before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item.) Prosthetic devices over \$1,000 in cost per device <p>If you don't notify us, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>Please refer to the Mental Health and Substance Use Disorder section for notification requirements pertaining to Mental Health and Substance Use Disorder treatment.</p> <p>**REFER TO SPECIFIC BENEFIT SECTION FOR APPLICABLE PENALTIES FOR NOTIFICATION</p>
<p>Ambulance Services – Emergency Only</p> <p>Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. Air transportation is covered if ground transportation is impossible or would put your life or health in serious jeopardy.</p>	<p>Ground Transportation:</p> <p>75% of eligible expenses after satisfying \$250 deductible.</p> <p>.</p> <p>Air Transportation:</p> <p>75% of eligible expenses after satisfying \$250 deductible.</p> <p>Ground Transportation:</p> <p>75% of eligible expenses after satisfying \$250 deductible.</p> <p>Air Transportation:</p> <p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Ground Transportation:</p> <p>75% of eligible expenses after satisfying \$250 Network deductible.</p> <p>Air Transportation:</p> <p>75% of eligible expenses after satisfying \$250 Network deductible.</p> <p>Ground Transportation:</p> <p>75% of eligible expenses after satisfying \$250 Network deductible.</p> <p>Air Transportation:</p> <p>75% of eligible expenses after satisfying \$250 Network deductible.</p>

<p>Ambulance Services - Non-Emergency The Plan also covers transportation provided by licensed professional ambulance, other than air ambulance, (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:</p> <ul style="list-style-type: none"> • From a non-Network Hospital to a Network Hospital; • To a Hospital that provides a higher level of care that was not available at the original Hospital; • To a more cost-effective acute care facility; or • From an acute facility to a sub-acute setting. 	<p>Not Covered</p>	<p>Not Covered</p>
<p>Ambulatory Surgical Center</p>	<p>Refer to <i>Surgery Outpatient</i> benefit below for a description of Covered Health Services.</p>	<p>Refer to <i>Surgery Outpatient</i> benefit below for a description of Covered Health Services.</p>
<p>Emergency Health Services- Outpatient</p> <p>Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.</p>	<p>\$500 copay then 100% of eligible expenses.</p> <p>If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services.</p> <p>Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency. (Non-emergency services are not covered.)</p>	<p>Same as Network Benefit</p> <p>If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services.</p> <p>Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency. (Non-emergency services are not covered.)</p> <p>Notification Required Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify us within 48 hours of the admission or on the same day of admission if reasonably</p>

		<p>possible after you are admitted to a non-Network Hospital or Alternate Facility If you don't notify us, Benefits for the Hospital Inpatient Stay will be reduced to 50% of Eligible Expenses.</p>
<p>Hospital Inpatient Stay</p> <p>If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room is not an allowable expense (unless the patient's stay in a private Hospital room is necessary in terms of generally accepted medical practice.)</p> <p>Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described under <u>Physician Fees for Surgical and Medical Services.</u></p> <p>Inpatient Stay in a Hospital. Benefits are available for:</p> <ul style="list-style-type: none"> ● Services and supplies received during the Inpatient Stay. ● Room and board in a Semi-private Room (a room with two or more beds). ● Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. <p>Benefits for Emergency admissions and admissions of less than 24 hours are described under <u>Emergency Health Services-Outpatient, Surgery – Outpatient, Scopic Procedures</u></p>	<p>100% after \$250 Deductible has been met and you pay a \$100 Copayment per day (Maximum 5 days)</p>	<p>Not Covered</p>

<p><u>– Diagnostic and Therapeutic Treatments – Outpatient,</u> respectively.</p> <p>UnitedHealth PremiumSM Program UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:</p> <ul style="list-style-type: none"> ● help you make informed decisions on where to receive care; ● provide you with decision support resources; and ● give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria. <p>For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto www.myuhc.com or call the toll-free number on your ID card.</p>		
<p>Lab, X-Ray and Diagnostics – Outpatient</p> <p>Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:</p> <ul style="list-style-type: none"> ● lab and radiology/x-ray; and ● mammography <p>Benefits under this section include:</p> <ul style="list-style-type: none"> ● the facility charge and the charge for supplies and equipment; and 	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>

- Physician services for anesthesiologists, pathologists and radiologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine – Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

Note:

75% of eligible expenses after satisfying \$250 deductible.

Not Covered

<p>Radiology notification required for outpatient MRI/MRA Scans, CT Scans, PET Scans and Nuclear Medicine Studies for services rendered by a Network Provider. The Network Provider will be sanctioned for non-notification. Network Providers Only - please select the "Radiology/ Notification prompt when confirming benefits for these services.</p>		
<p>Scopic Procedures – Outpatient Diagnostic and Therapeutic</p> <p>The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.</p> <p>Benefits under this section include:</p> <ul style="list-style-type: none"> • The facility charge and the charge for supplies and equipment; and • Physician services for anesthesiologists, pathologists and radiologists. <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services - Sickness and Injury</i>.</p> <p>Benefits for other Physician services are described under <i>Physician Fees for Surgical and Medical Services</i>.</p> <p>Please note that Benefits under</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>

<p>this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under <i>Surgery - Outpatient</i>. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.</p>		
<p>Surgery-Outpatient</p> <p>The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Benefits under this section include:</p> <ul style="list-style-type: none"> • The facility charge and the charge for supplies and equipment; and • Certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy) • Physician services for anesthesiologists, pathologists and radiologists. <p>Benefits for other Physician services are described under <u><i>Physician Fees for Surgical and Medical Services.</i></u></p> <p>When these services are performed in a Physician's office, Benefits are described under <u><i>Physician's Office Services – Sickness and Injury.</i></u></p> <p><u>Note:</u> Radiology notification required for outpatient MRI/MRA Scans, CT Scans, PET Scans and Nuclear Medicine Studies for services</p>	<p>100% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>

<p>rendered by a Network Provider. The Network Provider will be sanctioned for non-notification. Network Providers Only - please select the "Radiology/ Notification prompt when confirming benefits for these services.</p>		
<p>Therapeutic Treatments – Outpatient</p> <p>The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.</p> <p>Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:</p> <ul style="list-style-type: none"> • education is required for a disease in which patient self-management is an important component of treatment; and • there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional <p>Benefits under this section include:</p> <ul style="list-style-type: none"> • the facility charge and the charge for related supplies and equipment; and • Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under <u>Physician Fees for Surgical and Medical</u> 	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered.</p>

<p><u>Services</u></p> <p>When these services are performed in a Physician's office, Benefits are described under <u>Physician's Office Services – Sickness and Injury</u></p>		
<p>Urgent Care Center Services</p> <p>Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under <u>Physician's Office Services – Sickness and Injury.</u></p> <p>If the services is provided in an Urgent Care Center and the Urgent Care benefit is a flat dollar copayment, then benefits for the following will pay under the Urgent Care copay</p>	<p>\$25 copay per visit, then 100% of eligible expenses.</p>	<p>Not Covered</p>

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
<p>Intensive Care Unit</p> <p>UnitedHealth PremiumSM Program UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:</p> <ul style="list-style-type: none"> • help you make informed decisions on where to receive 	<p>100% after \$250 Deductible has been met and you pay a \$100 Copayment per day (Maximum 5 days)</p>	<p>Not Covered</p>

<p>care;</p> <ul style="list-style-type: none"> ● provide you with decision support resources; and ● give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria. <p>For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto www.myuhc.com or call the toll-free number on your ID card.</p>		
<p>Pre-Admission Testing</p>	<p>Refer to the appropriate benefit category.</p> <p>If services are rendered in an outpatient facility refer to the Outpatient Diagnostic benefit, which is described in the <i>Surgery - Outpatient</i> benefit category.</p> <p>If services are rendered in an office setting refer to the <i>Physician's Office Services – Sickness and Injury</i> benefit category.</p>	<p>Not Covered</p>

MATERNITY CARE

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
<p>Pregnancy – Maternity Services</p> <p>Includes prenatal care, delivery, postnatal care and any related complications.</p> <p>We will pay Benefits for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> ● 48 hours for the mother and newborn child following a normal vaginal delivery. ● 96 hours for the mother and 	<p>Same as:</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i> <p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>

<p>newborn child following a cesarean section delivery.</p> <p>These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay.</p> <p>If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.</p> <p>Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.</p> <p>The following services are not covered:</p> <ul style="list-style-type: none"> • Services provided by a doula (labor aide); • Parenting, pre-natal or birthing classes; 	<p>Physician office visits are paid at 100% for prenatal care after the first initial office visit copayment of \$15 for PCP or \$40 for specialist.</p>	
<p>Neonatal Resource Services (NRS)</p>	<p>Not Applicable</p>	<p>Not Applicable</p>
<p>Newborn Care</p> <p>Non-wellness services for a newborn child whose length of stay in the hospital exceeds the mother's length of stay.</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>
<p>Midwife</p>	<p>Covered same as <i>Pregnancy - Maternity Services</i> and <i>Newborn Care</i> sections above.</p>	<p>Not Covered</p>
<p>Birthing Center</p>	<p>Covered same as <i>Pregnancy -</i></p>	<p>Not Covered</p>

	Maternity Services and Newborn Care sections above.	
The Healthy Pregnancy Program	<p>A healthy pregnancy is the first step to a healthy baby and mom. The Healthy Pregnancy Program provides pregnancy consultation to identify special needs, written and on-line educational materials and resources, 24-hour toll-free access to experienced maternity nurses, and a phone call from a care coordinator during your pregnancy and about four weeks after your baby is born to see how things are going and answer questions you may have.</p> <p>Call 1-800-411-7984 Or Visit www.healthy-pregnancy.com</p>	Not Covered

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Newborn Process	<p>The child is automatically covered for a 31-day period under the employees SSN as "Baby Boy or Baby Girl." Claims incurred/submitted during this period of time will be paid. Any claims received after the 31-day period, (for DOS after the 31 days post-birth), will be denied unless child has already been added as a dependent.</p>	

PHYSICIAN SERVICES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Anesthesia	Services provided by facility based RAPLEs (i.e.,	Not Covered

	<p>radiologists, anesthesiologists, pathologists, labs, emergency room physicians) are covered as part of the facility benefit as described under <i>Hospital Inpatient Stay, Emergency Health Services - Outpatient or Surgery – Outpatient</i> categories. RAPL services associated with outpatient lab/diagnostics are described under the <i>Lab, X-ray and Diagnostics – Outpatient</i> benefit.</p>	
<p>Hemophilia Program</p>	<p>The following is excluded from coverage under the Specialty Pharmacy program:</p> <ul style="list-style-type: none"> • Hemophilia 	
<p>Nutritional Counseling</p> <p>Nutritional education provided in a Physician’s office by an appropriately licensed or healthcare professional when required for a disease in which patient self-management is an important component of treatment or there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.</p> <p>Some examples of such medical conditions include:</p> <ul style="list-style-type: none"> • Coronary artery disease; • Congestive heart failure; • Severe obstructive airway disease; • Gout; • Renal failure; • Phenylketonuria; and • Hyperlipidemias. <p>The following services are not covered:</p> <ul style="list-style-type: none"> • Nutritional counseling for either individuals or groups, 	<p>75% of eligible expenses after satisfying \$250 deductible.</p> <p>When nutritional counseling services are billed as a preventive care service, these services will be paid as described under <i>Preventive Care Services</i>.</p> <p><u>Nutritional Education:</u></p> <p><u>\$15</u> per office visit with Primary Physician or <u>\$40</u> per office visit with Specialist, then <u>100%</u> of eligible expenses.</p>	<p>Not Covered</p>

<p>except as identified under Diabetes Services and except as defined in this category;</p> <ul style="list-style-type: none"> ● Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy, <ul style="list-style-type: none"> ● Food of any kind. Foods that are not covered include: <ul style="list-style-type: none"> ● Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk; unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded ● Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; ● Oral vitamins and minerals; ● Meals you can order from a menu, for an additional charge, during an Inpatient Stay; and ● Other dietary and electrolyte supplements; and ● Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes. 		
<p>Physician's Office Services – Sickness and Injury</p> <p>Services provided in a Physician's office for the</p>	<p>\$15 Primary Physician/ \$40 Specialist copay per visit then 100% of eligible expenses.</p> <p>No copayment applies when no</p>	<p>Not Covered</p>

diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Covered Health Services for Preventive Care provided in a Physician's office are described under *Preventive Care Services*.

Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office.

Note - If the service is provided in a Physician Office Setting and the Physician Office benefit is a flat dollar copayment, then benefits for the following will pay under the office visit copay:

- Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient
- Pharmaceutical Products – Outpatient
- Scopic Procedures - Outpatient Diagnostic
- Surgery – Outpatient
- Therapeutic Treatments - Outpatient

Physician charge is assessed.

<p>Refer to <i>Rehabilitation Therapy</i> for a description of benefit coverage.</p> <p>UnitedHealth PremiumSM Program UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:</p> <ul style="list-style-type: none"> ● help you make informed decisions on where to receive care; ● provide you with decision support resources; and ● give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria. <p>For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto www.myuhc.com or call the toll-free number on your ID card.</p>		
<p>Preventive Care</p> <p>Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:</p>	<p>100% of eligible expenses.</p>	<p>Non-Network Benefits are not available.</p>

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing; and
- tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for

additional information regarding coverage available for specific services.		
<p>Physician Fees for Surgical and Medical Services</p> <p>When these services are performed in a Physician's office, Benefits are described under Physician's Office Services.</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>
<p>Second Surgical Opinion</p> <p>This is not a required service to obtain benefits.</p>	<p>Physician Office Services: \$15 copay per visit then 100% of eligible expenses.</p> <p>Specialist Office Services: \$40 copay per visit then 100% of eligible expenses.</p>	<p>Not Covered</p>
<p>Vision Care</p>	<p>\$25 copay per visit then 50% of eligible expenses.</p> <p>\$25 deductible per Calendar Year then 50% of eligible expenses (Plan Pays 50%) Benefits include one routine vision exam every calendar year. Hardware ,“ Frames”, lenses, and/or contacts, fitting • , including refraction, also covered under the medical plan at 50% of eligible expenses after satisfying \$25 deductible. Exams limited to one visit per covered person per calendar year. Frames limited to one pair per covered person per calendar year. Lenses limited to one pair</p>	<p>\$25 copay per visit then 50% of eligible expenses.</p> <p>Same as Network Benefit (Plan Pays 50%)</p>

	per covered person per calendar year. Contacts limited to one pair person per calendar year. Disposable contacts covered up to a years supply.	
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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Assistant Surgeon	75% of eligible expenses after satisfying \$250 deductible.	Not Covered
Cochlear Implants	Same as <ul style="list-style-type: none"> • <i>Physician's Office Services</i> • <i>Physician Fees for Surgical and Medical</i> • <i>Hospital-Inpatient Stay</i> • <i>Surgery-Outpatient</i> • <i>Durable Medical Equipment</i> 	Not Covered
Hemophilia Quick Tip	<p>This program only supports obtaining medications from a specific provider. Depending on the place of service, benefit information can be located within several applicable benefit categories.</p> <ul style="list-style-type: none"> • If Hemophilia Factor is a part of a carve-out situation, the carve-out Pharmacy Benefit Manager and/or Specialty Pharmacy vendor should be contacted to confirm coverage. • If administered on an outpatient basis in a Hospital, Alternate Facility, Physician's Office, or administered or directly supervised by a qualified provider or licensed/certified health professional in a Covered Persons' residence (during eligible Home Health Care or Physician House Calls) refer to <i>Pharmaceutical Products – Outpatient</i>. • If administered during an Emergency room visit, refer to <i>Emergency Health Services – Outpatient</i> for more information. • If self-administered (self-injected, self-infused, etc), refer to <i>Prescription Drugs</i> for more information. <p>For more information on coverage determination guidelines and codes, please use the <u>Specialty Pharmacy SOP</u> link.</p> <p><u>Exceptions - Lock out codes:</u> ASO clients who have opted into the Specialty Pharmacy Program can choose to opt out of certain therapeutic classes. The following opt outs exist and should be reflected in the <i>Specialty Pharmacy</i></p>	

	<p>Program section above – specifically the therapeutic class should be removed from the list and there should be a call out that that particular therapeutic class has been excluded from the program. A client can only opt out of one of the options below. This will be a very rare occurrence.</p> <ul style="list-style-type: none"> • Hemophilia • See <i>Specialty Pharmacy Program Quick tip</i> section for other classes that may be excluded as part of the Specialty Pharmacy Program 	
Multiple Surgical Procedures	100/50/50	100/50/50
Network Gap Exception – No Physician/Specialist within 30 miles of their home zip code.	Exception granted through care coordination ONLY prior to receipt of care. Exception will be documented in the CCS View/ARI screens if approved by Care Coordination.	
Non-Network Office Based Lab and Diagnostic Processing	<p>New Processing applies to Lab and Diagnostic services. Explanation: Benefits for lab/diagnostics services will be based solely on the network status of the lab/diagnostic provider, regardless of the network status of the ordering physician.</p>	
Preventive Care SPI Bundle	<p>This plan has elected coverage for additional services under the preventive care benefit beyond what is required by the federal health reform law (a/k/a PPACA or the Affordable Care Act). Refer to the <u>Preventive SPI Bundle Job Aid</u> in Knowledge Library for a list of the additional services covered by this plan as preventive.</p>	
RAPS Processing	<p>RAPLE = Radiologist, Anesthesiologist, Pathologist, Laboratory and Emergency Room Physician.</p> <p>RAPLE- Reimbursement of Out-of -network RAPLE providers is determined by the network status of the inpatient hospital or outpatient surgical facility. In network benefits follow the Inpatient Hospital or Outpatient Surgery benefit category.</p>	

FAMILY PLANNING

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Birth Control Pills	See <i>Prescription Drug Section</i> for pharmacy benefits.	See <i>Prescription Drug Section</i> for pharmacy benefits.
ParentStepsSM	ParentSteps Infertility Centers of Excellence Network provides	

	<p>access to some of the best infertility clinics in the country. These clinics have high pregnancy rates AND low incidence of multiple births. ParentSteps offers the ability to purchase treatment cycles and infertility medications at group discount prices. ParentSteps also provides infertility nurse specialists who can educate you on your diagnosis and treatment options.</p> <p>For information concerning infertility treatment, please visit ParentSteps at www.myoptumhealthparentsteps.com or call 1-866-774-4626.</p>	
<p>Reproductive Resource Services Program (RRS)</p>	<p>Not Applicable.</p>	
<p>Infertility Services</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p> <p>The following service is covered:</p> <ul style="list-style-type: none"> ● Diagnosis of underlying condition only. <p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Health services and associated expenses for infertility treatments. ● Artificial Insemination, ● GIFT, and ● ZIFT Office visits are limited to \$5,000 per lifetime. 	<p>Not Covered</p>
<p>Reproduction</p> <p>Female contraceptive services, supplies and voluntary sterilization are covered the same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.</p>	<p>Same as:</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i> <p>Applicable services:</p> <ul style="list-style-type: none"> ● Voluntary sterilization. ● Fetal reduction surgery <p>Refer to Reproduction-Exclusions for services that are not covered.</p>	<p>Not Covered</p>

Reproduction-Exclusions	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● The following infertility treatment-related services: <ul style="list-style-type: none"> ● cryo-preservation and other forms of preservation of reproductive materials; ● long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue; and ● donor services; ● in vitro fertilization which is not provided as an Assisted Reproductive Technology for the treatment of infertility; ● surrogate parenting, donor eggs, donor sperm and host uterus; ● the reversal of voluntary sterilization ● artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes; ● elective surgical, non-surgical or drug induced Pregnancy termination; <p>This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage)</p> <ul style="list-style-type: none"> ● services provided by a doula (labor aide); and ● parenting, pre-natal or birthing classes 	
Tubal Ligation	Female contraceptive services, supplies and voluntary sterilization are covered the same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.	Female contraceptive services, supplies and voluntary sterilization are covered the same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.
Vasectomy	<p>Same as:</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services - Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Surgery - Outpatient</i> 	Not Covered.

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
<p>Diaphragm</p> <p>Covered for device, fitting and removal.</p> <p>Female contraceptive services, supplies and voluntary sterilization are covered the</p>	<p>100% of eligible expenses.</p>	<p>Non-Network Benefits are not available.</p>

same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.		
Depo Provera Female contraceptive services, supplies and voluntary sterilization are covered the same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.	100% of eligible expenses.	Non-Network Benefits are not available.
IUD Covered for device, fitting and removal. Female contraceptive services, supplies and voluntary sterilization are covered the same as Preventive Care Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.	100% of eligible expenses.	Non-Network Benefits are not available.

SPECIAL SERVICES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
<p>Acupuncture Services</p> <p>Acupuncture services provided if the service is performed in an office setting by a Provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body: in the Provider's office.</p> <ul style="list-style-type: none"> • Doctor of Medicine; 	<p>75% of eligible expenses after satisfying \$250 deductible.</p> <p>Benefits are limited to \$1,000 per calendar year. Needle Therapy and all other services covered by acupuncturist covered up to \$1,000 max.</p>	Not Covered.

<ul style="list-style-type: none"> • Doctor of Osteopathy; • Chiropractor; or • Acupuncturist. 		
Allergy Care	75% of eligible expenses after satisfying \$250 deductible.	Not Covered
Allergy Injections	75% of eligible expenses after satisfying \$250 deductible.	Not Covered
Bariatric Resource Services (BRS)	Not Applicable.	
<p>Breast Pumps</p> <p>Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth.</p> <p>Benefits are only available if breast pumps are obtained from a DME provider or Physician.</p>	100% of eligible expenses.	Not Covered.

<p>Cancer Resource Services (CRS)</p>	<p>Access to the CRS Centers of Excellence Network gives patients care that is planned, coordinated and provided by a team of experts who specialize in their specific cancer. Potential benefits include accurate diagnosis, appropriate therapy (neither too little nor too much), higher survival rates and decreased costs.</p> <p>Network benefits are available for patients who receive care at a designated Cancer Resource Services Network facility.</p> <p>Participation in this program is voluntary for the enrollee. To ensure network benefits are received under this program, patients, or someone on their behalf, must contact Cancer Resource Services at 1-866-936-6002 before receiving care. More information is also available at www.myoptumhealthcomplexmedical.com</p> <p>Travel and Lodging Assistance is not available as part of the Cancer Resource Services program.</p>	
<p>Chemotherapy</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered.</p>
<p>Clinical Trials</p> <p>Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:</p> <ul style="list-style-type: none"> • Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted; • Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below; • Surgical musculoskeletal disorders of the spine, hip, 	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category.</p> <p>Pre-service Notification Requirement You must notify us as soon as the possibility of participation in a clinical trial arises.</p>	<p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category.</p> <p>Pre-service Notification Requirement You must notify us as soon as the possibility of participation in a clinical trial arises.</p> <p>If you don't notify us, Benefits will be reduced to 50% of Eligible Expenses .</p>

<p>and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below; and</p> <ul style="list-style-type: none"> • Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below. <p>Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying clinical trial.</p> <p>Benefits are available only when the Covered Person is clinically eligible for participation in the clinical trial as defined by the researcher.</p> <p>Routine patient care costs for clinical trials include:</p> <ul style="list-style-type: none"> • Covered Health Services for which Benefits are typically provided absent a clinical trial. • Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications. • Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service. 		
<p>Congenital Heart Disease Resource Services (CHDRS)</p>	<p>100% after \$250 Deductible has been met and you pay a \$100 Copayment per day (Maximum 5 days)</p>	<p>Not Covered</p>

	<p>Access to the CHD Centers of Excellence Network gives patients care that is planned, coordinated and provided by a team of experts who specialize in treating Congenital Heart Disease. Potential benefits include accurate diagnosis, appropriate surgical interventions, higher survival rates and decreased costs.</p> <p>Network benefits are available for patients who receive care at a designated CHD Centers of Excellence Network facility.</p> <p>Participation in this program is voluntary for the enrollee. To help ensure network benefits are received under this program, patients, or someone on their behalf, should contact CHD Resource Services at 1-888-936-7246 before receiving care. More information is also available <u>online</u>.</p> <p>Travel and Lodging Assistance is available as part of the Congenital Heart Disease Resource Services program. \$50/\$100 per diem with a Lifetime Maximum of \$10,000.</p>	
<p>Dental Services – Accident Only</p> <p>Dental services are covered by the Plan when all of the following are true:</p> <ul style="list-style-type: none"> • treatment is necessary because of accidental damage; • dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth; • dental services are received 	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>

from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and

- the dental damage is severe enough that initial contact with a Physician or dentist occurs within **72** hours of the accident. (You may request an extension of this time period provided that you do so within **60** days of the Injury and if extenuating circumstances exist due to the severity of the Injury)

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate

Dental services for final treatment to repair the damage caused by accidental Injury must be started within **3** months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within **12** months of the accident.

The Plan pays for treatment of accidental Injury only for:

- emergency examination
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;

- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Please remember that you should notify us as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification, before the initial Emergency treatment. When you provide notification, we can determine whether the service is a Covered Health Service.

The following services are not covered:

- 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.
- Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:
 - extractions (including wisdom teeth);
 - restoration and replacement of teeth;
 - medical or surgical treatments of dental conditions; and
 - services to improve dental clinical outcomes;
- dental implants, bone grafts,

<p>and other implant-related procedures;</p> <ul style="list-style-type: none"> ● dental braces (orthodontics); ● dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia (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 as described above; and ● treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate. 		
<p>Durable Medical Equipment</p> <p>The plan pays for Durable Medical Equipment that is:</p> <ul style="list-style-type: none"> ● Ordered or provided by a Physician for outpatient use; ● Used for medical purposes; ● Not consumable or disposable; ● Not of use to a person in the absence of a sickness, injury or disability; ● Durable enough to withstand repeated use; and ● Appropriate for use in the home. <p>If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>

pump) and for repairs of that unit. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- insulin pumps and all related necessary supplies as described under ***Diabetes Services***;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage; and
- equipment for the treatment

<p>of chronic or acute respiratory failure or conditions.</p> <p>The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with Durable Medical Equipment.</p> <p>Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.</p> <p>Foot Orthotics -should be covered combined with DME</p> <p>Notification Required</p> <p>Please remember that for Benefits you must notify us before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (purchase, rental, repair or replacement of Durable Medical Equipment).</p> <p>If you don't notify us, Benefits will be reduced to 50% of Eligible Expenses</p>		
<p>Foreign Travel</p> <p>Do not cover flights back to the United States from a foreign country under any circumstance.</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Healthy Back Program</p>	<p>Not Applicable</p>	
<p>Healthy Weight Program</p>	<p>Not Applicable</p>	

<p>Hearing Aids Coverage for hearing loss as the result of an accidental injury only.</p> <p>The Plan pays Benefits for hearing aids which are required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.</p> <p>Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.</p> <p>Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:</p> <ul style="list-style-type: none"> ● craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or ● hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. 	<p>50% of eligible expenses after satisfying \$250 deductible. Coverage for accidental injury only</p>	<p>Not Covered.</p>
<p>Home Health Care</p> <p>Covered Health Services are services that a Home Health</p>	<p>100% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>

Agency provides if you need care in your home due to the nature of your condition.

Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Glossary; and
- provided on a part-time, intermittent schedule when Skilled Care is required. Refer to Glossary for the definition of Skilled Care.

We will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be “skilled” simply because there is not an available caregiver

Skilled care is skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- A physician orders them;
- They are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- They require clinical training in order to be delivered safely and effectively; and
- They are not Custodial

The following services are not covered:

- Custodial Care.
- Domiciliary care.
- Respite care.
- Rest cures.

Benefits are limited to **60** visits per calendar year. One visit equals four hours of skilled home health care services.

This visit limit does not include any service which is billed only for the administration of intravenous infusion.

<p>Care.</p> <p>Custodial Care is defined as services that do not require special skills or training and that:</p> <ul style="list-style-type: none"> ● Provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating); ● Do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or ● Do not require continued administration by trained medical personnel in order to be delivered safely and effectively. 		
<p>Hospice Care</p> <p>Hospice Care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are only available when hospice care is received from a licensed hospice agency, which can include a Hospital.</p>	<p>100% of eligible expenses after satisfying \$250 deductible.</p> <p>Benefits are limited to 180 days during the entire period of time you are covered under the Policy.</p>	<p>Not Covered</p>
<p>Kidney Resource Services (KRS)</p>	<p>Kidney Resource Services provides access to top-performing dialysis centers and nurse consulting services to support the management of kidney diseases. Kidney transplantation candidates</p>	

	<p>have access to the Transplant Centers of Excellence Network and Transplant Resource Services nurse consulting services.</p> <p>Please call a KRS nurse at 1-866-561-7518 for all inquiries and notifications. Information is also available at https://www.myoptumhealthcomplexmedical.com</p>	
<p>Lasik surgery</p>	<p>50% of billed charges, limited to \$2,000 lifetime, combined in and out-of-network. The following services are not covered: Â· Photo Refractive Keratecomy (PRK) Â· Radial Keratotomy</p>	<p>50% of billed charges, limited to \$2,000 lifetime, combined in and out-of-network. The following services are not covered: Â· Photo Refractive Keratecomy (PRK) Â· Radial Keratotomy</p>
<p>Ostomy Supplies</p> <p>Benefits for ostomy supplies are limited to:</p> <ul style="list-style-type: none"> • Pouches, face plates and belts. • Irrigation sleeves, bags and ostomy irrigation catheters. • Skin barriers. <p>Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered.</p>
<p>Pharmaceutical Products – Outpatient</p> <p>The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, or in a Covered Person's home.</p> <p>Examples of what would be included under this category include:</p> <ul style="list-style-type: none"> • inhaled medication in an urgent care center for treatment of an asthma attack. <p>When these services are</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered.</p>

<p>performed in a Physician's office, Benefits are described under <i>Physician's Office Services - Sickness and Injury</i>.</p> <p>Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy</p>		
<p>Private Duty Nursing – Inpatient</p>	<p>Not Covered.</p> <p>The following service is not covered:</p> <ul style="list-style-type: none"> ● Private duty nursing 	<p>Not Covered.</p> <p>The following service is not covered:</p> <ul style="list-style-type: none"> ● Private duty nursing
<p>Prosthetic Devices</p> <p>Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:</p> <ul style="list-style-type: none"> ● artificial arms, legs, feet and hands; ● artificial face, eyes, ears and nose; ● breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, 	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>

<p>including mastectomy bras and lymphedema stockings for the arm.</p> <p>Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses</p> <p>If more than 1 prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost</p> <p>Notification Required</p> <p>Please remember that for Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed \$1,000 in cost per device.</p> <p>If you don't obtain prior authorization, Benefits will be reduced to 50% of Eligible Expenses.</p>		
<p>Reconstructive Procedures</p> <p>Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated</p>	<p>Same as</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Surgery - Outpatient</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i> 	<p>Same as</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Surgery - Outpatient</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i>

<p>with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.</p> <p>Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women’s Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.</p> <p>Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures.</p> <p>The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure</p> <p>For Benefits you must notify us 5 business days before a</p>	<p>You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy related services.</p>	<p>You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy related services.</p>
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<p>scheduled reconstructive procedure is performed. When you provide notification, we can determine whether the service is considered reconstructive or cosmetic. Cosmetic procedures are always excluded from coverage.</p> <p>In addition, for Non-Network Benefits you must notify us 24 hours before admission for an Inpatient Stay.</p> <p>If you don't notify us, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>Note: See exclusions described under <i>Physical Appearance</i>.</p>		
<p>Rehabilitation and Habilitative Services Outpatient Therapy and Manipulative Treatment</p> <p>Short-term outpatient rehabilitation services for:</p> <ul style="list-style-type: none"> • Physical therapy; • Occupational therapy; • Manipulative treatment • Speech therapy; • Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident; • Pulmonary rehabilitation therapy; and • Cardiac rehabilitation therapy. <p>For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>

<p>The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant</p> <p>Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.</p> <p>Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.</p>		
<p>Shoe Orthotics</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p> <p>Shoe orthotics are covered for diagnosis of Diabetes only.</p>	<p>Not Covered</p>
<p>Skilled Nursing Facility Inpatient Rehabilitation Facility Services</p> <p>Benefits include: Non-Physician services and supplies received during the Inpatient Stay; Room and board in a semi-private room (a room with two or more beds); and Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists.</p> <p>Benefits for other Physician services, are described under</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p> <p>Benefits are limited to 60 days per calendar year.</p>	<p>Not Covered</p>

Physician Fees for Surgical and Medical Services.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely

<p>and effectively.</p> <p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Custodial Care. ● Domiciliary care. 		
<p>Sleep Disorders</p>	<p>The following services are covered: Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Appliances for snoring</p> <p>75% of eligible expenses after satisfying \$250 deductible.</p> <p>limited to, \$5,000 per lifetime</p>	<p>Not Covered</p>
<p>Spinal/Manipulative Treatment</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p> <p>Benefits for Spinal Treatment are limited to \$1,000 per calendar year.</p>	<p>Not Covered</p>
<p>Transplantation Services</p> <p>Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Provider and received at a Designated United Resource Networks Facility. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which benefits are available include but are not limited to:</p> <ul style="list-style-type: none"> ● Heart; ● Heart/lung; ● Lung; ● Kidney; ● Kidney/pancreas; ● Liver; 	<p>Voluntary</p> <p>100% of eligible expenses.</p> <p>Travel and Lodging United Resource Networks will assist the patient and family with travel and lodging arrangements related to:</p> <ul style="list-style-type: none"> ● Congenital Heart Disease (CHD); and ● Transplantation services ; and <p>For travel and lodging services to be covered, the patient must be receiving services at a Designated United Resource Networks Facility.</p> <p>The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:</p>	<p>Voluntary</p> <p>Non-Network Benefits are not available.</p>

- Liver/kidney;
- Liver/intestinal;
- Pancreas;
- Intestinal; and
- Bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy.

Benefits are also available for cornea transplants.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

Pre-service Notification Requirement

For Network Benefits you must notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify us and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid.

If you fail to notify us as required, Benefits will be reduced to **50%** of Eligible Expenses.

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
 - Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to **\$50** per day for the patient or up to **\$100** per day for the patient plus one companion; or
 - If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to **\$100** per day.
- Travel and lodging expenses are only available if the recipient lives more than **50** miles from the Designated United Resource Networks Facility (for Transplantation) or the CHD facility. The Company must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:
- Airfare at coach rate;
 - Taxi or ground transportation; or
 - Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated United Resource Networks Facility.

A combined overall maximum Benefit of **\$10,000** per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all transplant procedures

	and CHD treatments during the entire period that person is covered under this Plan.	
Wigs Wigs are covered when temporary loss of hair results from the treatment of a malignancy.	75% of eligible expenses after satisfying \$250 deductible.	Not Covered.

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Alternative Treatments	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Acupressure ● Aromatherapy. ● Hypnotism. ● Massage Therapy. ● Roling. (holistic tissue massage); ● Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary 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 under <u>Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.</u> 	
Bereavement Counseling	75% of eligible expenses after satisfying \$250 deductible	Not Covered
Breast Reconstruction	<p>Same as</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i> 	<p>Same as</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i>
Breast Reduction	Not Covered except as required by the Women's Health and Cancer Rights Act of 1998.	Not Covered except as required by the Women's Health and Cancer Rights Act of 1998.
Devices, Appliances and	The following services are not covered:	

<p>Prosthetics</p>	<ul style="list-style-type: none"> • devices used specifically as safety items or to affect performance in sports-related activities; • orthotic appliances and devices that straighten or reshape a body part, except as described under <i>Durable Medical Equipment</i>. <p>Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over the counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.</p> <ul style="list-style-type: none"> • cranial banding; • the following items are excluded, even if prescribed by a Physician: <ul style="list-style-type: none"> • blood pressure cuff/monitor; • enuresis alarm; • non-wearable external defibrillator; • trusses; and • ultrasonic nebulizers; • the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect; • the replacement of lost or stolen prosthetic devices; • devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment; • oral appliances for snoring; <p>This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures.</p>	
<p>Diabetes Services</p> <p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p> <p>Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.</p> <p>Benefits under this section also include medical eye examinations (dilated retinal</p>	<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category.</p> <p>Diabetes Self-Management Items</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be</p>	<p>Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category.</p> <p>Diabetes Self-Management Items</p> <p>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be</p>

<p>examinations) and preventive foot care for Covered Persons with diabetes.</p> <p>Diabetes Self-Management Items</p> <p>Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under <i>Durable Medical Equipment</i>. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described under the <i>Prescription Drugs</i>.</p> <p>Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under <i>Durable Medical Equipment</i>.</p> <p>Diabetic office visits waive the copay Diabetes related labs whether in the office or at a network lab will be covered at 100%, deductible does not apply. Out of network not covered.</p>	<p>the same as those stated under <i>Durable Medical Equipment</i> and <i>Prescription Drugs</i>.</p>	<p>the same as those stated under <i>Durable Medical Equipment</i> and <i>Prescription Drugs</i>.</p>
<p>Dialysis</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered</p>
<p>Disposable Medical Supplies</p>	<p>Not Covered.</p>	<p>Not Covered.</p>
<p>Drugs</p>	<p>The following services are not covered under the medical portion of the plan:</p> <ul style="list-style-type: none"> ● Prescription drug for outpatient use that are filled by a prescription order or refill; 	

	<ul style="list-style-type: none"> • self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting); • Growth hormone therapy; • Non-injectable medications given in a Physician's office except as required in an Emergency; and consumed in the Physician's office; and • Over the counter drugs and treatments <p>See <i>Prescription Drug</i> section for a list of coverages.</p>	
Enteral Nutrition	Not Covered	Not Covered.
Experimental or Investigational or Unproven Services	This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.	This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.
Foot Care Foot Orthotics -should be covered combined with DME	<p>The following services are not covered:</p> <ul style="list-style-type: none"> • Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under <i>Diabetes Services</i>. Routine foot care services that are not covered include: <ul style="list-style-type: none"> • Cutting or removal of corns and calluses; • Nail trimming or cutting; and • Debriding (removal of dead skin or underlying tissue); • Hygienic and preventive maintenance foot care. Examples include the following: <ul style="list-style-type: none"> • Cleaning and soaking the feet; • Applying skin creams in order to maintain skin tone; and • Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot; <p>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</p> <ul style="list-style-type: none"> • Treatment of flat feet; • Treatment of subluxation of the foot. 	
Gynecomastia	<p>The following service is not covered:</p> <ul style="list-style-type: none"> • Treatment of benign gynecomastia (abnormal breast enlargement in males.) 	
Medical Supplies	The following services are not covered:	

	<ul style="list-style-type: none"> ● Prescribed or non-prescribed medical and disposable supplies. Examples of supplies that are not covered include, but are not limited to: <ul style="list-style-type: none"> ● elastic stockings, ace bandages, diabetic strips, and syringes; and ● urinary catheters ● tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment; and ● the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect; and ● the replacement of lost or stolen Durable Medical Equipment;and ● deodorants, filters, lubricants, tape, appliance clears, adhesive, or adhesive remover or other items that are not specifically identified in <i>Ostomy Supplies</i>. <p>This exclusion does not apply to:</p> <ul style="list-style-type: none"> ● ostomy bags and related supplies for which Benefits are provided as described under <i>Ostomy Supplies</i>; ● disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under <i>Diabetes Services</i>; ● diabetic supplies for which Benefits are provided as described under <i>Diabetes Services</i>; 	
Morbid Obesity	Not Covered	Not Covered
Nutrition and Health Education	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy; ● nutritional counseling for either individuals or groups, except as defined under <i>Nutritional Counseling</i>; ● Food of any kind. Foods that are not covered include: ● enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition and unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; ● foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; ● oral vitamins and minerals; ● meals you can order from a menu, for an additional charge, during an Inpatient Stay; and ● other dietary and electrolyte supplements; and <p>Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.</p>	

Orthognathic Surgery	Not Covered.	Not Covered.
Personal Care, Comfort or Convenience	<p>The following services are not covered: Supplies, equipment and similar incidentals for personal comfort. Examples include:</p> <ul style="list-style-type: none"> ● Television; ● Telephone; ● Beauty/barber service ● Guest service; <p>Supplies, equipment and similar incidentals for personal comfort. Examples include</p> <ul style="list-style-type: none"> ● Air conditioners; ● Guest service; ● Air purifiers and filters; ● Batteries and battery chargers; ● Dehumidifiers and humidifiers; ● Ergonomically correct chairs; ● Non-Hospital beds and comfort beds, motorized beds and mattresses; ● 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; ● Electric scooters; ● Exercise equipment and treadmills; ● hot tubs, Jacuzzis, saunas and whirlpools; ● medical alert systems; ● music devices; ● personal computers; ● pillows; ● power-operated vehicles; ● radios; ● strollers; ● safety equipment; ● vehicle modifications such as van lifts; ● video players; and ● Home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides). 	
Physical Appearance	<p>The following services are not covered: Cosmetic Procedures are excluded. Examples include:</p> <ul style="list-style-type: none"> ● Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; ● Pharmacological regimens; ● Nutritional procedures or treatments; ● Tattoo or scar removal or revision procedures (such as 	

	<p>salabrasion, chemosurgery and other such skin abrasion procedures);</p> <ul style="list-style-type: none"> • hair removal or replacement by any means; • treatments for skin wrinkles or any treatment to improve the appearance of the skin; • treatment for spider veins; • skin abrasion procedures performed as a treatment for acne; • treatments for hair loss; • varicose vein treatment of the lower extremities, when it is considered cosmetic; and • Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure; • Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments 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. • Non-surgical treatment of obesity..
<p>Procedures and Treatment</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> • biofeedback; • medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer).; • post-cochlear implant aural therapy • 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 but not limited to routine, long-term or maintenance/preventive treatment; • speech therapy to treat stuttering, stammering, or other articulation disorders • speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under <i>Rehabilitation Services – Outpatient Therapy</i> • a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy; • excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty); • psychosurgery (lobotomy); • • chelation therapy, except to treat heavy metal poisoning;

	<ul style="list-style-type: none"> • Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies; • 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; • sex transformation operations; • non-surgical treatment, even if for morbid obesity; and • surgical treatment of obesity even if there is a diagnosis of morbid obesity; • Medical and surgical treatment of hyperhidrosis (excessive sweating); and <ul style="list-style-type: none"> • the following Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances, surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations; • upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment, except as treatment of obstructive sleep apnea; and • breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures; 	
<p>Providers</p>	<p>The following services are not covered: Services:</p> <ul style="list-style-type: none"> • Performed by a Provider who is a family member by birth or marriage, including your spouse, brother, sister, parent or child; • A provider may perform on himself or herself; • Performed by a provider with your same legal residence; • Services ordered or delivered by a Christian Science practitioner; • Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license; • Provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider; • Which are self-directed to a free-standing or Hospital-based diagnostic facility; and • Ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care: <ul style="list-style-type: none"> • Prior to ordering the service; or • After the service is received. <p>This exclusion does not apply to mammography testing.</p>	
<p>Radiation Therapy</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p>	<p>Not Covered.</p>

<p>Services Provided Under Another Plan</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Services for which coverage is available: <ul style="list-style-type: none"> ● Under another plan, except for Eligible Expenses payable as described under <i>Coordination of Benefits</i>; ● Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you; ● While on active military duty; and ● For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible. 	
<p>Smoking Cessation</p> <p>Limited to \$500 per calendar year and \$1,000 per lifetime - includes coverage for drugs and related office visits.</p>	<p>75% of eligible expenses after satisfying \$250 deductible.</p> <p>At Office: \$15 Primary Physician/ \$40 Specialist copay per visit then 100% of eligible expenses.</p>	<p>Not Covered.</p>
<p>Temporomandibular Joint (TMJ) Services</p> <p>The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.</p> <p>Diagnostic treatment includes examination, radiographs and applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections</p> <p>Benefits are provided for surgical treatment if:</p> <ul style="list-style-type: none"> ● there is clearly demonstrated radiographic evidence of significant joint abnormality; ● non-surgical treatment has failed to adequately resolve the symptoms; and 	<p>Same as</p> <ul style="list-style-type: none"> ● <i>Physician's Office Services – Sickness and Injury</i> ● <i>Physician Fees</i> ● <i>Hospital-Inpatient Stay</i> ● <i>Surgery - Outpatient</i> ● <i>Lab, X-ray and Diagnostics – Outpatient</i> ● <i>Therapeutic Treatments - Outpatient</i> <p>limited to \$5,000 per lifetime. Coverage is available for the evaluation and treatment of temporomandibular joint syndrome (TMJ), including surgery.</p> <p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances, surface electromyography; Doppler analysis; 	<p>Not Covered.</p>

<ul style="list-style-type: none"> ● pain or dysfunction is moderate or severe. <p>Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include FDA-approved TMJ implants only when all other treatment has failed.</p> <p>Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described under <u><i>Hospital – Inpatient Stay</i></u> and <u><i>Physician Fees for Surgical and Medical Services</i></u>, respectively.</p>	<p>vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.</p>	
<p>Travel</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Health services provided in a foreign country , unless required as Emergency Health Services; ● Travel or transportation expenses, even if ordered by a Physician, except as identified under <i>Travel and Lodging</i>. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan’s discretion. 	
<p>Types of Care</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Custodial Care or maintenance care; ● Domiciliary Care; ● multi-disciplinary pain management programs provided on an inpatient basis; ● 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 described under Hospice Care; ● rest cures; ● services of personal care attendants; and ● Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work). 	
<p>Vision and Hearing</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● bone anchored hearing aids except when either of the following applies: <ul style="list-style-type: none"> ● for Covered Persons with craniofacial anomalies whose 	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive

	<p>abnormal or absent ear canals preclude the use of a wearable hearing aid; or</p> <ul style="list-style-type: none"> ● for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid and ● Eye exercise or vision therapy; ● Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy. <p>Please refer to <i>Vision Care</i> section for a description of covered services for vision.</p>	<p>devices;</p> <ul style="list-style-type: none"> ● Eye exercise or vision therapy; ● Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy. <p>Please refer to <i>Vision Care</i> section for a description of covered services for vision.</p>
<p>Wisdom Teeth</p>	<p>Not Covered.</p>	<p>Not Covered.</p>
<p>All Other Exclusions</p>	<p>The following services are not covered:</p> <ul style="list-style-type: none"> ● Autopsies and other coroner services and transportation services for a corpse; ● Charges for: <ul style="list-style-type: none"> ● Missed appointments; ● Room or facility reservations; ● Completion of claim forms; or ● Record processing; ● Charges prohibited by federal anti-kickback or self-referral statutes; ● Diagnostic tests that are: <ul style="list-style-type: none"> ● Delivered in other than a Physician’s office or health care facility; and ● Self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests; ● Expenses for health services and supplies: <ul style="list-style-type: none"> ● That do not meet the definition of a Covered Health Service; ● That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force 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 a non-war zone; ● That are received after the date your coverage under this Plan ends, including health services for medical conditions 	

	<p>which began before the date your coverage under the Plan ends;</p> <ul style="list-style-type: none"> ● 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 this benefit Plan; ● That exceed Eligible Expenses or any specified limitation; ● For which a Provider waives the Copay, Deductible or Coinsurance amounts; ● foreign language and sign language services; ● Long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; ● Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatment when: <ul style="list-style-type: none"> ● Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; ● Conducted for purposes of medical research; ● Related to judicial or administrative proceedings or orders; <p>or</p> <ul style="list-style-type: none"> ● Required to obtain a license of any type.
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PRESCRIPTION DRUGS

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Pharmacy Benefit Manager (PBM)	 <p>OptumRx For all pharmacy support, please refer to the telephone number on the back of your ID card.</p>	
<p>Prescription Drug Definition</p> <p>A medication, product or device that has been approved by the Food and Drug Administration and that can only be legally dispensed using a prescription order or refill. A Prescription Drug is appropriate for self-administration or administration by a non-skilled caregiver.</p>	<p>Benefits are available for Prescription Drugs at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug is listed.</p> <p>Benefits for Prescription Drugs are available when the Prescription Drug meets the definition of a Covered Health Service.</p>	
Step Therapy	<p>Certain Prescription Drugs for which Benefits are described in this section or Pharmaceutical Products for which Benefits are described under your medical Benefits are subject to step therapy requirements. This means that in order to receive Benefits for such</p>	

	<p>Prescription Drugs or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Product(s) first.</p> <p>You may determine whether a particular Prescription Drug or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling the telephone number on your ID card.</p>	
What You Must Pay	<p>You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table.</p> <p>You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.</p>	
Annual Drug Deductible	<p>Network and Non-Network No Annual Drug Deductible.</p>	
Out-of-Pocket Drug Maximum	<p>See Out-of-Pocket Maximum (OOPM) -under this pharmacy coverage plan, the deductible & out-of-pocket maximum include both medical and pharmacy expenses.</p>	
Infertility Maximum Policy Benefit	<p>Not Applicable</p>	
<p>Retail Purchases</p> <p>Notification Requirements Before certain prescription drugs are dispensed to you, it is the responsibility of your physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the prescription drug is:</p> <ul style="list-style-type: none"> ● A Covered Health Service as defined by the Plan; and ● Not Experimental and Investigational or Unproven. <p>If UnitedHealthcare is not notified before the prescription drug is dispensed, you may pay more for that prescription drug order or refill. You will be required to pay for the</p>	<p>Coverage up to 31-day supply.</p> <ul style="list-style-type: none"> ● Tier 1: \$10 copay then 100% of eligible expenses. ● Tier 2: \$25 copay then 100% of eligible expenses. ● Tier 3: \$50 copay then 100% of eligible expenses. <p>Note: Tier 1 was previously referred to as Generic, Tier 2 was previously referred to as Preferred Brands and Tier 3 was previously referred to as Non-Preferred drugs or Brand Name Drugs that are not included on</p>	<p>Not Covered</p>

<p>prescription drug at the time of purchase. To determine if a prescription drug requires notification, either visit myuhc.com or call the toll-free number on your ID card. The prescription drugs requiring notification are subject to UnitedHealthcare’s periodic review and modification.</p>	<p>the Prescription Drug List.</p>	
<p>Mail Order Purchases</p>	<p>Coverage up to 90-day supply</p> <ul style="list-style-type: none"> ● Tier 1: \$25 copay then 100% of eligible expenses. ● Tier 2: \$50 copay then 100% of eligible expenses. ● Tier 3: \$50 copay then 100% of eligible expenses. <p>Note: Tier 1 was previously referred to as Generic, Tier 2 was previously referred to as Preferred Brands and Tier 3 was previously referred to as Non-Preferred drugs or Brand Name Drugs that are not included on the Prescription Drug List.</p>	<p>Not Covered</p>
<p>Health Care Reform Preventive Care Medications</p>	<p>Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined below.</p> <p>Health Care Reform Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:</p> <ul style="list-style-type: none"> ● Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. ● With respect to infants, children and adolescents, evidence- 	

	<p>informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.</p> <ul style="list-style-type: none"> • With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. <p>You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling the telephone number on your ID card.</p>
<p>Specialty Pharmacy Program</p> <p>Self- administered Diabetes products DO NOT fall into this category</p>	<p>Not Applicable – Has not opted into the Specialty Pharmacy Program</p>

CSR View

<p>Situation</p>	<p>2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK</p>	<p>2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK</p>
<p>OptumRx</p> <p>Refer to VCC Desktop for all telephone numbers.</p>	<p>Fresh Start Customer</p> <p><u>General Commercial Pharmacy Help Desk (Public Line)</u> Designed to assist with Pharmacy inquiries, can also assist with compound drug verification, emergency refills, vacation overrides (emergency refills and vacation overrides are initiated by the pharmacy)</p> <p><u>Prior Authorization Department</u> Press 1 for standard oral medications Press 2 for Specialty Drugs This number may be disclosed to the member, ensure that they have their physician contact this number directly for immediate assistance. Many prior authorizations can be completed in real time.</p> <p><u>OptumRx Mail Service Member Line</u> This is the standard OptumRx Mail Order Dept, where the member will initially be taken into an automated system. If the member is new to mail order they can select the appropriate prompt. The Mail Service Dept can also provide general assistance with the OptumRx member website. In the event the member needs additional assistance, they will connect our members with a tech representative.</p> <p><u>Specialty Pharmacy Patient Care Coordinator Line</u> <i>Prescriber/Member New Prescription or New Services</i></p>	

	<p>When a member is transferred to this number, they will receive assistance with their drug questions, coverage verification, prior auth if needed, and setting up an account for ordering.</p> <p><u>Specialty Pharmacy Patient Care Coordinator Line</u> <i>Prescriber/Member Refill Prescription on Existing Services</i> Member can contact this number to refill their specialty medication. Please be aware that this number is for REFILL only.</p> <p><u>Doctor to Registered Pharmacist Line</u> This line should only be used by doctors or their authorized staff who are calling in new prescriptions or refills to be used at Mail Service.</p> <p>BPL Number: 62502</p>
<p>Specialty Pharmacy Program Quick Tip</p>	<ul style="list-style-type: none"> The UnitedHealthcare Specialty Pharmacy Program applies to pharmacy benefits only. Reference the Customer Service drug list available on PharWeb (<i>access through customer service SOP</i>) to verify specialty medications subject to this program. This program DOES NOT determine benefit coverage - this program only supports obtaining medications from a specific provider. <p>Exceptions: Lock out codes ASO clients who have opted into the Specialty Pharmacy Program can choose to opt out of certain therapeutic classes. The following opt outs exist and should be reflected in the <i>Specialty Pharmacy Program</i> section above – specifically the therapeutic class should be removed from the list and there should be a call out that that particular therapeutic class has been excluded from the program. A client can only opt out of one of the options below. This will be a very rare occurrence.</p> <ul style="list-style-type: none"> Hemophilia – will be addressed in <i>Hemophilia Program</i> section HIV/Aids & Transplant (<i>exclusion will be for both classes if client has chosen this opt out</i>) Oral Oncology

OTHER BENEFITS

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN
Dental Vendor	Administrator: UnitedHealthcare Dental Phone Number: 1-877-816-3596
Discount Program	Health Discount Program, offered through UnitedHealth Allies Call 1-800-860-8773 Accessed via myuhc.com or www.unitedhealthallies.com

Health & Wellness	Optum Health & Wellness Online resources Access resources online at www.myuhc.com For Online content and technical questions call 1-866-868-5484.
hi HealthInnovations™ Hearing Program	<p>Hearing loss can affect your life in many ways. It can cause anxiety, depression, isolation and frustration. There is help. Through <i>hi HealthInnovations</i> and your medical plan administered by UnitedHealthcare, you can get customized hearing aids for a fraction of the cost you would have paid at other retailers.</p> <p>Through <i>hi HealthInnovations™</i> members can pay a discounted rate for high-quality, custom-programmed hearing aids, starting at \$479 each, saving them thousands of dollars in out-of-pocket-costs. There is no cost to members to access this program to take advantage of special member pricing</p> <p>Three steps to better hearing</p> <p>1. Ask your health care provider for a hearing test Your medical plan pays for a hearing test if recommended by a physician. If you've already been tested within the past year, fax your results to 1-877-955-4336 to receive hearing aid recommendations. Go to www.hiHealthInnovations.com/united for more information.</p> <p>2. Choose your hearing aid Based on your hearing test results, select from recommended hearing aids that are programmed specifically for you and delivered right to your door.</p> <p>Each hearing aid comes with:</p> <ul style="list-style-type: none"> • FREE batteries and ear tubes/wax guards that will last most users six months • 45-day no-risk trial period • One-year manufacturer's warranty <p>3. Place your order Get started on the path to better hearing today! Log on to www.hiHealthInnovations.com/united to check out what hearing aid would be best for you and see your low member pricing.</p> <p>You can also call 1-866-926-6632, 8a.m. to 6p.m. CT, Monday through Friday to place an order or to get more information.</p>
Incentives for Health	NOT APPLICABLE
Simply Engaged Wellness Incentive Program	NOT APPLICABLE

Vision Vendor	Administered by: UnitedHealthcare Vision <ul style="list-style-type: none"> • Call 1-800-638-3120 <p>Please contact UnitedHealthcare Vision to verify eligibility and coverage for routine vision.</p>
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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Carve Out Disease Management Program	Not Applicable	
Diabetes Prevention and Control Alliance (DPCA)	Diabetes Prevention and Control Alliance is an OUTBOUND program and participants are directed based on claims data analysis, health screenings and physician referrals. If the participant has lost the mailing and/or information to Diabetes Prevention and Control Alliance available at external participating vendors such as the local YMCAs and/or local pharmacies, please REFER the caller to 1-888-688-4019.	

MENTAL HEALTH

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Vendor	Administered by: United Behavioral Health –Health Plan Division <ul style="list-style-type: none"> • Call: 1-800-842-5724 • EAP • Does Not Apply 	Administered by: United Behavioral Health –Health Plan Division <ul style="list-style-type: none"> • Call: 1-800-842-5724 • EAP • Does Not Apply
Mental Health Services Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an	Services received on an inpatient basis in a Hospital or Alternate Facility: 75% of eligible expenses after satisfying the \$250 deductible. Services received on an outpatient basis in a	Services received on an inpatient basis in a Hospital or Alternate Facility: 60% of eligible expenses after satisfying \$500 deductible. Services received on an outpatient basis in a

<p>Alternate Facility.</p> <p>Benefits include the following services provided on either an outpatient or inpatient basis:</p> <ul style="list-style-type: none"> ● diagnostic evaluations and assessment; ● treatment planning; ● referral services; ● medication management; ● individual, family, therapeutic group and provider-based case management services; and ● crisis intervention. <p>Benefits include the following services provided on an inpatient basis:</p> <ul style="list-style-type: none"> ● Partial Hospitalization/Day Treatment; ● services at a Residential Treatment Facility; <p>Benefits include the following services provided on an outpatient basis:</p> <ul style="list-style-type: none"> ● Intensive Outpatient Treatment; <p>The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p> <p>You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.</p> <p>Special Mental Health Programs and Services Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services</p>	<p>provider's office or at an Alternate Facility:</p> <p>\$40 copay per visit then 100% of eligible expenses.</p> <p>You are not required to provide pre-service notification when you seek these services from Network providers. Network providers are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.</p> <p>Network provider ONLY will be responsible for obtaining the following notification requirements:</p> <ul style="list-style-type: none"> ● Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management <p>For a scheduled admission, Network provider must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, Network provider must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro- 	<p>provider's office or at an Alternate Facility: 60% of eligible expenses after satisfying \$500 deductible.</p> <p>Notification Required You must provide pre-service notification as described below.</p> <p>When Benefits are provided for any of the services listed below, the following services require notification:</p> <ul style="list-style-type: none"> ● Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. <p>For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication
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<p>benefit.</p> <p>The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use.</p> <p>Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.</p>	<p>convulsive treatment;</p> <ul style="list-style-type: none"> ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management 	<p>management.</p> <p>If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to 50% of Eligible Expenses</p>
<p>Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</p> <p>The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:</p> <ul style="list-style-type: none"> ● Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and ● Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in 	<p>Services received on an inpatient basis in a Hospital or Alternate Facility:</p> <p>80% of eligible expenses after satisfying the \$750 deductible.</p> <p>Services received on an outpatient basis in a provider's office or at an Alternate Facility:</p> <p>\$40 copay per visit then 100% of eligible expenses.</p> <p>You are not required to provide pre-service notification when you seek these services from Network</p>	<p>Services received on an inpatient basis in a Hospital or Alternate Facility:</p> <p>60% of eligible expenses after satisfying \$500 deductible.</p> <p>Services received on an outpatient basis in a provider's office or at an Alternate Facility:</p> <p>60% of eligible expenses after satisfying \$500 deductible.</p> <p>Notification Required</p> <p>You must provide pre-service notification as described below.</p>

<p>daily functioning.</p> <p>These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories covered by the plan.</p> <p>Benefits include the following services provided on either an outpatient or inpatient basis:</p> <ul style="list-style-type: none"> ● diagnostic evaluations and assessment; ● treatment planning; ● referral services; ● medication management; ● individual, family, therapeutic group and provider-based case management services; and ● crisis intervention <p>Benefits include the following services provided on an inpatient basis:</p> <ul style="list-style-type: none"> ● Partial Hospitalization/Day Treatment ● services at a Residential Treatment Facility. <p>Benefits include the following services provided on an outpatient basis:</p> <ul style="list-style-type: none"> ● Intensive Outpatient Treatment. <p>The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p> <p>You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for</p>	<p>providers. Network providers are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.</p> <p>Network provider ONLY will be responsible for obtaining the following notification requirements:</p> <ul style="list-style-type: none"> ● Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorder - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. <p>For a scheduled admission, Network provider must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, Network provider must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management 	<p>When Benefits are provided for any of the services listed below, the following services require notification:</p> <ul style="list-style-type: none"> ● Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorder - inpatient services (including partial hospitalization/day treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. <p>For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. <p>If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to 50% of Eligible Expenses</p>
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referrals to providers and coordination of care.		
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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Inpatient Coinsurance apply to Out-of-pocket	Yes	Yes
Outpatient Coinsurance apply to Out-of-pocket	Not Applicable	Yes

SUBSTANCE ABUSE

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Vendor	Administered by: United Behavioral Health-HealthPlan Division <ul style="list-style-type: none"> ● Call: 1-800-842-5724 EAP <ul style="list-style-type: none"> ● Does Not Apply 	Administered by: United Behavioral Health-HealthPlan Division <ul style="list-style-type: none"> ● Call: 1-800-842-5724 EAP <ul style="list-style-type: none"> ● Does Not Apply
Substance Use Disorder Services Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits include the following services provided on either an inpatient or outpatient basis: <ul style="list-style-type: none"> ● diagnostic evaluations 	Services received on an inpatient basis in a Hospital or Alternate Facility: 75% of eligible expenses after satisfying the \$250 deductible Services received on an outpatient basis in a provider's office or at an Alternate Facility: \$40 copay per visit then 100% of eligible expenses.	Services received on an inpatient basis in a Hospital or Alternate Facility: 60% of eligible expenses after satisfying \$500 deductible. Services received on an outpatient basis in a provider's office or at an Alternate Facility: 60% of eligible expenses after satisfying \$500 deductible. Notification Required You must provide pre-service

<p>and assessment;</p> <ul style="list-style-type: none"> ● treatment planning; ● referral services; ● medication management; ● individual, family, therapeutic group and provider-based case management; ● crisis intervention. ● detoxification (sub-acute/non-medical); <p>Benefits include the following services provided on an inpatient basis:</p> <ul style="list-style-type: none"> ● Partial Hospitalization/Day Treatment; ● services at a Residential Treatment Facility; <p>Benefits include the following services provided on an outpatient basis:</p> <ul style="list-style-type: none"> ● Intensive Outpatient Treatment; <p>The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p> <p>You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.</p> <p>Special Substance Use Disorder Programs and Services</p> <p>Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit.</p>	<p>You are not required to provide pre-service notification when you seek these services from Network providers. Network providers are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.</p> <p>Network provider ONLY will be responsible for obtaining the following notification requirements:</p> <ul style="list-style-type: none"> ● Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management <p>For a scheduled admission, Network provider must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, Network provider must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with or 	<p>notification as described below.</p> <p>When Benefits are provided for any of the services listed below, the following services require notification:</p> <ul style="list-style-type: none"> ● Substance Use Disorder Services - inpatient services (including partial hospitalization/day treatment and services at a Residential Treatment facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. <p>For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.</p> <ul style="list-style-type: none"> ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond 45-50 minutes in duration, with or without medication management. <p>If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.</p>
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<p>The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use.</p> <p>Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.</p>	<p>without medication management</p>	
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CSR View

<p>Situation</p>	<p>2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK</p>	<p>2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK</p>
<p>Mental Health and Substance Use Disorder Services</p>	<p>Exclusions listed directly below apply to services described under <i>Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders and/or Substance Use Disorders</i></p> <p>The following services are not covered:</p> <ul style="list-style-type: none"> • Services performed in connection with conditions not classified in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i>; • services or supplies for the diagnosis or treatment of Mental Illness , alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: <ul style="list-style-type: none"> • not consistent with generally accepted standards of 	

- medical practice for the treatment of such conditions;
- not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
 - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
 - not clinically appropriate for the patient's mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.
 - Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
 - Mental Health Services as treatment for a primary diagnosis of insomnia, other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;
 - Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and, paraphilias (sexual behavior that is considered deviant or abnormal);
 - educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
 - tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act;
 - learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
 - mental retardation as a primary diagnosis defined 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 for drug addiction;
 - intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders;
 - 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.

Inpatient Coinsurance apply to Out-of-pocket	Yes	Yes
Outpatient Coinsurance apply to Out-of-pocket	Not Applicable	Yes

Attachment I - Retiree and COBRA Medical Census

TYPE	PLAN	COVERAGE LEVEL	Birth Date	GENDER	ZIP CODE
COBRA	Advantage Plus	PARTICIPANT ONLY	08/15/1952	F	75454
COBRA	Advantage Plus	PARTICIPANT ONLY	10/09/1965	F	75034
COBRA	Advantage Plus	PARTICIPANT ONLY	05/19/1950	F	75002
COBRA	Advantage Plus	PARTICIPANT ONLY	01/31/1950	F	75069
COBRA	Advantage Plus	PARTICIPANT ONLY	05/23/1952	M	75713
RETIREE	Advantage	PARTICIPANT ONLY	07/04/1951	M	75495
RETIREE	Advantage	PARTICIPANT ONLY	11/07/1949	M	75773
RETIREE	Advantage	PARTICIPANT + SPOUSE	12/28/1945	M	75069
RETIREE	Advantage Plus	PARTICIPANT + SPOUSE	11/09/1949	M	75074
RETIREE	Advantage Plus	PARTICIPANT + CHILDREN	06/23/1953	F	75070
RETIREE	Advantage Plus	PARTICIPANT ONLY	10/15/1953	F	75418
RETIREE	Advantage Plus	PARTICIPANT ONLY	10/07/1949	M	75454
RETIREE	Advantage Plus	PARTICIPANT + SPOUSE	06/29/1948	F	75248
RETIREE	Advantage Plus	PARTICIPANT + SPOUSE	01/12/1940	F	75070
RETIREE	Advantage Plus	PARTICIPANT + SPOUSE	09/14/1949	M	75020
RETIREE	Advantage Plus	PARTICIPANT ONLY	01/05/1950	F	75098

Attachment J - Active Employee Medical Census

Sex	Birthdate	Annual Rt	Descr	Covrg Cd	Postal
M	8/29/1982	34532.790	Advantage Plus- Prem Discount	Employee Only	75454
M	6/20/1962	49309.730	Advantage Plus- Prem Discount	Employee Only	75401
F	2/2/1958	47111.340	Advantage Plus- Prem Discount	Employee Only	75090
F	2/16/1974	41706.788	Advantage Plus- Prem Discount	Employee Only	75495
F	4/22/1969	65690.030	Advantage Plus- Prem Discount	Employee Only	76208
F	9/5/1966	54555.170	Advantage Plus- Prem Discount	Employee Only	75401
M	11/17/1952	56857.820	Advantage Plus- Prem Discount	Employee Only	75418
M	9/5/1951	39554.520	Advantage Plus- Prem Discount	Employee Only	75409
F	7/2/1974	29777.110	Advantage Plus- Prem Discount	Employee Only	75069
F	10/28/1966	43042.880	Advantage Plus- Prem Discount	Employee Only	75485
F	3/15/1953	95583.680	Advantage Plus- Prem Discount	Employee Only	75034
M	3/10/1956	83803.000	Advantage Plus- Prem Discount	Employee Only	75423
F	5/5/1958	31538.750	Advantage Plus- Prem Discount	Employee Only	75407
F	4/22/1971	70560.980	Advantage Plus- Prem Discount	Employee Only	75070
F	12/23/1982	44946.970	Advantage Plus- Prem Discount	Employee Only	75407
F	5/6/1948	36201.520	Advantage Plus- Prem Discount	Employee Only	75442
F	6/8/1963	54298.110	Advantage Plus- Prem Discount	Employee Only	75424
M	7/9/1952	66638.000	Advantage Plus- Prem Discount	Employee Only	75424
F	8/13/1958	37137.240	Advantage Plus- Prem Discount	Employee Only	75490
F	5/28/1950	35841.490	Advantage Plus- Prem Discount	Employee Only	75098
F	10/19/1966	94674.040	Advantage Plus- Prem Discount	Employee Only	75078
M	7/5/1969	65124.090	Advantage Plus- Prem Discount	Employee Only	75070
F	5/26/1973	47849.390	Advantage Plus- Prem Discount	Employee Only	75090
M	6/24/1952	51253.360	Advantage Plus- Prem Discount	Employee Only	75424
F	1/9/1960	47849.390	Advantage Plus- Prem Discount	Employee Only	75459
M	6/13/1958	47849.390	Advantage Plus- Prem Discount	Employee Only	75459
M	11/4/1981	49588.410	Advantage Plus- Prem Discount	Employee Only	75490
F	9/27/1984	40827.730	Advantage Plus- Prem Discount	Employee Only	75013
F	3/24/1957	63008.350	Advantage Plus- Prem Discount	Employee Only	75069
F	2/2/1967	43159.940	Advantage Plus- Prem Discount	Employee Only	75407
F	12/15/1975	52241.590	Advantage Plus- Prem Discount	Employee Only	75479
M	3/28/1954	44314.660	Advantage Plus- Prem Discount	Employee Only	75491
F	4/5/1941	31639.890	Advantage Plus- Prem Discount	Employee Only	75002
F	9/22/1974	47377.810	Advantage Plus- Prem Discount	Employee Only	75454
M	6/13/1952	27902.920	Advantage Plus- Prem Discount	Employee Only	75009
M	11/2/1974	55435.190	Advantage Plus- Prem Discount	Employee Only	75442
M	3/4/1948	56857.820	Advantage Plus- Prem Discount	Employee Only	75490
M	5/25/1967	47849.390	Advantage Plus- Prem Discount	Employee Only	75092
F	7/16/1974	44317.900	Advantage Plus- Prem Discount	Employee Only	75092
M	1/3/1970	83804.150	Advantage Plus- Prem Discount	Employee Only	75409
F	12/21/1948	34646.270	Advantage Plus- Prem Discount	Employee Only	75025
F	3/30/1952	41212.400	Advantage Plus- Prem Discount	Employee Only	75490
M	7/29/1952	83804.150	Advantage Plus- Prem Discount	Employee Only	75070
M	12/20/1979	64528.260	Advantage Plus- Prem Discount	Employee Only	75070

Attachment J - Active Employee Medical Census

M	9/9/1971	43788.670	Advantage Plus- Prem Discount	Employee Only	75069
F	5/3/1976	48822.980	Advantage Plus- Prem Discount	Employee Only	75092
M	7/13/1959	65115.980	Advantage Plus- Prem Discount	Employee Only	75442
M	10/14/1951	42814.550	Advantage Plus- Prem Discount	Employee Only	75071
M	9/29/1971	38842.930	Advantage Plus- Prem Discount	Employee Only	75069
M	1/13/1936	47849.390	Advantage Plus- Prem Discount	Employee Only	75069
M	8/20/1964	72322.210	Advantage Plus- Prem Discount	Employee Only	75089
M	7/12/1962	68639.000	Advantage Plus- Prem Discount	Employee Only	75069
F	12/9/1960	67920.150	Advantage Plus- Prem Discount	Employee Only	75071
M	7/29/1967	57826.630	Advantage Plus- Prem Discount	Employee Only	75002
F	8/8/1957	38048.300	Advantage Plus- Prem Discount	Employee Only	75495
F	1/13/1959	48058.860	Advantage Plus- Prem Discount	Employee Only	75409
F	8/27/1966	48723.620	Advantage Plus- Prem Discount	Employee Only	75462
F	2/4/1970	84518.910	Advantage Plus- Prem Discount	Employee Only	75089
M	11/7/1966	52196.060	Advantage Plus- Prem Discount	Employee Only	75495
F	6/7/1968	36556.490	Advantage Plus- Prem Discount	Employee Only	75495
M	7/31/1982	47849.390	Advantage Plus- Prem Discount	Employee Only	75485
F	5/26/1956	57018.380	Advantage Plus- Prem Discount	Employee Only	75069
F	6/26/1940	62599.470	Advantage Plus- Prem Discount	Employee Only	75002
F	8/17/1951	37801.400	Advantage Plus- Prem Discount	Employee Only	75002
F	1/21/1952	43767.480	Advantage Plus- Prem Discount	Employee Only	75078
F	6/11/1977	44949.460	Advantage Plus- Prem Discount	Employee Only	75407
F	5/25/1961	32069.510	Advantage Plus- Prem Discount	Employee Only	75023
M	7/9/1968	41729.870	Advantage Plus- Prem Discount	Employee Only	75407
F	10/25/1978	41911.000	Advantage Plus- Prem Discount	Employee Only	75401
F	4/28/1947	34383.680	Advantage Plus- Prem Discount	Employee Only	75071
F	10/14/1946	44317.100	Advantage Plus- Prem Discount	Employee Only	75071
M	9/7/1951	55793.400	Advantage Plus- Prem Discount	Employee Only	75424-6322
F	7/4/1961	29432.370	Advantage Plus- Prem Discount	Employee Only	75069
F	2/29/1956	48997.860	Advantage Plus- Prem Discount	Employee Only	75442
F	3/9/1957	47227.070	Advantage Plus- Prem Discount	Employee Only	75424
F	6/13/1957	44317.100	Advantage Plus- Prem Discount	Employee Only	75424
M	1/9/1951	68639.000	Advantage Plus- Prem Discount	Employee Only	75044
M	2/27/1967	52235.770	Advantage Plus- Prem Discount	Employee Only	75173
M	11/3/1962	52188.900	Advantage Plus- Prem Discount	Employee Only	75452
F	10/5/1958	118450.000	Advantage Plus- Prem Discount	Employee Only	76264
F	8/9/1961	36575.720	Advantage Plus- Prem Discount	Employee Only	75409
F	9/10/1974	62262.670	Advantage Plus- Prem Discount	Employee Only	75409
F	4/29/1964	52307.510	Advantage Plus- Prem Discount	Employee Only	75071
M	4/17/1952	38019.990	Advantage Plus- Prem Discount	Employee Only	75020
F	7/28/1955	29903.510	Advantage Plus- Prem Discount	Employee Only	75418
F	6/16/1965	95583.680	Advantage Plus- Prem Discount	Employee Only	75013
M	10/3/1965	68638.200	Advantage Plus- Prem Discount	Employee Only	75495
F	10/8/1959	40827.730	Advantage Plus- Prem Discount	Employee Only	75409
F	11/3/1952	41803.490	Advantage Plus- Prem Discount	Employee Only	75407

Attachment J - Active Employee Medical Census

M	7/10/1973	72693.100	Advantage Plus- Prem Discount	Employee Only	75442
F	10/28/1981	29368.470	Advantage Plus- Prem Discount	Employee Only	75409
M	3/24/1975	73231.040	Advantage Plus- Prem Discount	Employee Only	75069
M	8/24/1973	62489.140	Advantage Plus- Prem Discount	Employee Only	75071
F	4/8/1973	56093.640	Advantage Plus- Prem Discount	Employee Only	75424
F	8/13/1985	53762.310	Advantage Plus- Prem Discount	Employee Only	75495
F	8/13/1961	44317.100	Advantage Plus- Prem Discount	Employee Only	75069
F	2/7/1958	52448.780	Advantage Plus- Prem Discount	Employee Only	75409
F	9/8/1966	52043.330	Advantage Plus- Prem Discount	Employee Only	75025
M	2/2/1954	67750.100	Advantage Plus- Prem Discount	Employee Only	75085
F	3/13/1975	44068.300	Advantage Plus- Prem Discount	Employee Only	75409
M	1/30/1966	134658.550	Advantage Plus- Prem Discount	Employee Only	75002
F	10/25/1977	47849.390	Advantage Plus- Prem Discount	Employee Only	75009
M	3/2/1953	73208.860	Advantage Plus- Prem Discount	Employee Only	75454-0302
M	6/14/1975	74557.950	Advantage Plus- Prem Discount	Employee Only	75070
F	3/14/1974	46527.550	Advantage Plus- Prem Discount	Employee Only	75407
F	7/7/1966	58753.870	Advantage Plus- Prem Discount	Employee Only	75090
F	11/16/1949	44317.100	Advantage Plus- Prem Discount	Employee Only	75495
M	12/17/1960	83804.150	Advantage Plus- Prem Discount	Employee Only	75035
F	2/11/1960	32340.520	Advantage Plus- Prem Discount	Employee Only	75002
F	4/8/1959	131195.330	Advantage Plus- Prem Discount	Employee Only	75074
F	5/8/1961	45987.460	Advantage Plus- Prem Discount	Employee Only	75070
F	4/6/1977	91563.000	Advantage Plus- Prem Discount	Employee Only	75071
F	12/4/1974	48058.860	Advantage Plus- Prem Discount	Employee Only	75009
M	8/5/1977	54835.200	Advantage Plus- Prem Discount	Employee Only	75409
F	7/31/1956	47849.390	Advantage Plus- Prem Discount	Employee Only	75074
F	3/12/1965	74979.380	Advantage Plus- Prem Discount	Employee Only	76247
F	1/21/1964	49578.800	Advantage Plus- Prem Discount	Employee Only	75491
F	6/5/1956	68638.200	Advantage Plus- Prem Discount	Employee Only	75071
F	4/8/1949	68638.200	Advantage Plus- Prem Discount	Employee Only	75070
F	1/10/1986	51231.960	Advantage Plus- Prem Discount	Employee Only	75409
F	10/9/1978	33140.650	Advantage Plus- Prem Discount	Employee Only	75002
F	6/27/1960	38151.970	Advantage Plus- Prem Discount	Employee Only	75070
M	2/10/1959	35264.000	Advantage Plus- Prem Discount	Employee Only	75418
F	9/1/1963	50580.180	Advantage Plus- Prem Discount	Employee Only	75402
F	4/30/1975	36519.100	Advantage Plus- Prem Discount	Employee Only	75070
F	1/8/1964	82691.100	Advantage Plus- Prem Discount	Employee Only	75010
M	8/24/1971	59454.570	Advantage Plus- Prem Discount	Employee Only	75035
F	3/4/1961	98697.700	Advantage Plus- Prem Discount	Employee Only	75044
M	8/11/1978	46192.870	Advantage Plus- Prem Discount	Employee Only	75020
F	3/17/1956	47942.570	Advantage Plus- Prem Discount	Employee Only	75098
F	10/16/1958	43965.940	Advantage Plus- Prem Discount	Employee Only	75078
F	9/15/1958	68471.610	Advantage Plus- Prem Discount	Employee Only	75409
F	10/31/1953	47897.290	Advantage Plus- Prem Discount	Employee Only	75069
F	12/18/1962	87550.000	Advantage Plus- Prem Discount	Employee Only	75002

Attachment J - Active Employee Medical Census

F	1/3/1968	62590.220	Advantage Plus- Prem Discount	Employee Only	75495
F	12/25/1985	43500.760	Advantage Plus- Prem Discount	Employee Only	75070
F	11/4/1959	92532.360	Advantage Plus- Prem Discount	Employee Only	75069
F	11/1/1961	47849.390	Advantage Plus- Prem Discount	Employee Only	75044
M	8/19/1953	39327.060	Advantage Plus- Prem Discount	Employee Only	75452
F	8/24/1960	51873.680	Advantage Plus- Prem Discount	Employee Only	75452
F	2/22/1985	38446.000	Advantage Plus- Prem Discount	Employee Only	75407
M	10/1/1952	43270.630	Advantage Plus- Prem Discount	Employee Only	75071
F	2/1/1955	56973.440	Advantage Plus- Prem Discount	Employee Only	75409
F	2/9/1960	33914.600	Advantage Plus- Prem Discount	Employee Only	75407
M	10/31/1959	47849.390	Advantage Plus- Prem Discount	Employee Only	75407
F	8/18/1952	84487.770	Advantage Plus- Prem Discount	Employee Only	75010
F	4/4/1970	47849.390	Advantage Plus- Prem Discount	Employee Only	75409
M	7/31/1983	49612.595	Advantage Plus- Prem Discount	Employee Only	75459
F	10/29/1964	44140.160	Advantage Plus- Prem Discount	Employee Only	75069
F	6/23/1942	36232.240	Advantage Plus- Prem Discount	Employee Only	75243
F	4/24/1972	52087.440	Advantage Plus- Prem Discount	Employee Only	75409
F	10/26/1954	30369.140	Advantage Plus- Prem Discount	Employee Only	75026-1606
M	12/14/1980	53119.800	Advantage Plus- Prem Discount	Employee Only	75069
F	9/12/1962	37952.510	Advantage Plus- Prem Discount	Employee Only	75002
F	6/14/1957	73231.040	Advantage Plus- Prem Discount	Employee Only	75071
F	9/8/1978	45895.500	Advantage Plus- Prem Discount	Employee Only	75071
F	11/16/1963	54185.000	Advantage Plus- Prem Discount	Employee Only	75023
F	6/26/1974	52235.770	Advantage Plus- Prem Discount	Employee Only	75401
F	9/25/1952	67419.370	Advantage Plus- Prem Discount	Employee Only	75452
F	1/24/1951	38797.000	Advantage Plus- Prem Discount	Employee Only	75407
F	4/8/1950	47739.730	Advantage Plus- Prem Discount	Employee Only	75020
F	9/3/1968	52139.550	Advantage Plus- Prem Discount	Employee Only	75126
M	9/19/1946	47849.390	Advantage Plus- Prem Discount	Employee Only	75069
M	12/21/1948	49573.580	Advantage Plus- Prem Discount	Employee Only	75068
M	11/15/1955	75656.950	Advantage Plus- Prem Discount	Employee Only	75028
M	4/5/1970	40827.730	Advantage Plus- Prem Discount	Employee Only	75407
F	9/16/1973	100855.010	Advantage Plus- Prem Discount	Employee Only	75070
M	3/19/1953	56857.820	Advantage Plus- Prem Discount	Employee Only	75491-4747
M	8/8/1971	73231.040	Advantage Plus- Prem Discount	Employee Only	75490
F	1/17/1956	47227.070	Advantage Plus- Prem Discount	Employee Only	75442
M	5/2/1954	47849.390	Advantage Plus- Prem Discount	Employee Only	75071
F	9/25/1963	50745.670	Advantage Plus- Prem Discount	Employee Only	75442
F	10/13/1978	85319.540	Advantage Plus- Prem Discount	Employee Only	75071
F	7/20/1968	44387.030	Advantage Plus- Prem Discount	Employee Only	75407
F	11/2/1972	76931.110	Advantage Plus- Prem Discount	Employee Only	75023
M	9/23/1980	29921.100	Advantage Plus- Prem Discount	Employee Only	75009
F	6/4/1970	50241.860	Advantage Plus- Prem Discount	Employee Only	75488
M	12/20/1960	44284.910	Advantage Plus- Prem Discount	Employee Only	75488
F	1/27/1950	32156.560	Advantage Plus- Prem Discount	Employee Only	75070

Attachment J - Active Employee Medical Census

F	1/26/1959	52286.140	Advantage Plus- Prem Discount	Employee Only	75490
F	4/5/1977	45189.000	Advantage Plus- Prem Discount	Employee Only	75070
M	4/27/1945	80507.640	Advantage Plus- Prem Discount	Employee Only	75075
F	7/30/1971	47849.390	Advantage Plus- Prem Discount	Employee Only	75407
F	5/26/1962	73553.790	Advantage Plus- Prem Discount	Employee Only	75002
F	9/21/1958	33929.790	Advantage Plus- Prem Discount	Employee Only	75454
F	1/22/1963	47849.390	Advantage Plus- Prem Discount	Employee Only	75407
F	7/4/1955	47849.390	Advantage Plus- Prem Discount	Employee Only	75442
M	10/23/1972	39432.160	Advantage Plus- Prem Discount	Employee Only	75074
M	1/14/1987	35378.000	Advantage Plus- Prem Discount	Employee Only	75490
M	7/22/1973	32640.000	Advantage Plus- Prem Discount	Employee Only	75069
F	1/22/1970	40642.970	Advantage Plus- Prem Discount	Employee Only	75070
M	3/20/1973	44399.860	Advantage Plus- Prem Discount	Employee Only	75071
M	4/21/1949	90315.730	Advantage Plus- Prem Discount	Employee Only	75071
F	6/5/1947	43212.670	Advantage Plus- Prem Discount	Employee Only	75071
M	10/3/1948	41424.080	Advantage Plus- Prem Discount	Employee Only	75035
F	6/11/1976	40126.240	Advantage Plus- Prem Discount	Employee Only	75002
M	10/8/1984	49093.050	Advantage Plus- Prem Discount	Employee Only	75007
M	7/7/1974	37830.900	Advantage Plus- Prem Discount	Employee Only	75071
F	1/18/1966	37625.820	Advantage Plus- Prem Discount	Employee Only	75035
M	7/3/1960	59916.370	Advantage Plus- Prem Discount	Employee Only	75035
F	11/13/1954	42103.310	Advantage Plus- Prem Discount	Employee Only	75495
F	7/18/1970	49254.000	Advantage Plus- Prem Discount	Employee Only	75490
F	1/23/1949	91455.580	Advantage Plus- Prem Discount	Employee Only	75069
F	2/23/1978	42412.010	Advantage Plus- Prem Discount	Employee Only	75154
F	4/11/1972	38145.540	Advantage Plus- Prem Discount	Employee Only	75424
M	8/14/1987	38446.000	Advantage Plus- Prem Discount	Employee Only	75070
M	11/15/1988	58034.330	Advantage Plus- Prem Discount	Employee Only	75070
M	5/9/1965	42103.000	Advantage Plus- Prem Discount	Employee Only	75070
M	8/20/1974	46844.240	Advantage Plus- Prem Discount	Employee Only	75424
F	3/23/1984	62756.000	Advantage Plus- Prem Discount	Employee Only	75070
M	12/10/1972	63106.770	Advantage Plus- Prem Discount	Employee Only	75409
F	3/15/1945	45797.000	Advantage Plus- Prem Discount	Employee Only	75069
M	11/10/1980	75880.660	Advantage Plus- Prem Discount	Employee Only	75206
F	7/19/1959	35600.430	Advantage Plus- Prem Discount	Employee Only	75407
F	2/16/1965	33601.710	Advantage Plus- Prem Discount	Employee Only	75069
F	8/16/1977	52252.600	Advantage Plus- Prem Discount	Employee Only	75023
F	3/21/1961	33415.150	Advantage Plus- Prem Discount	Employee Only	75070
F	9/7/1978	36795.440	Advantage Plus- Prem Discount	Employee Only	75002
M	6/17/1949	37824.150	Advantage Plus- Prem Discount	Employee Only	75069
M	1/23/1970	41739.620	Advantage Plus- Prem Discount	Employee Only	75092
M	1/18/1977	36795.440	Advantage Plus- Prem Discount	Employee Only	75407
F	9/4/1969	32640.000	Advantage Plus- Prem Discount	Employee Only	75002
F	11/14/1989	32640.000	Advantage Plus- Prem Discount	Employee Only	75013
F	11/14/1953	36795.440	Advantage Plus- Prem Discount	Employee Only	75097

Attachment J - Active Employee Medical Census

M	11/21/1957	37935.530	Advantage Plus- Prem Discount	Employee Only	75418
F	1/10/1952	28455.740	Advantage Plus- Prem Discount	Employee Only	75454
M	5/27/1980	70057.270	Advantage Plus- Prem Discount	Employee Only	75251
M	3/28/1967	28260.020	Advantage Plus- Prem Discount	Employee Only	75454
M	9/27/1956	98658.510	Advantage Plus- Prem Discount	Employee Only	75094
F	11/4/1952	26084.000	Advantage Plus- Prem Discount	Employee Only	75070
F	2/21/1959	32640.000	Advantage Plus- Prem Discount	Employee Only	75074
F	10/12/1948	30506.770	Advantage Plus- Prem Discount	Employee Only	75002
F	3/15/1961	42281.990	Advantage Plus- Prem Discount	Employee Only	75025
M	6/16/1967	41339.730	Advantage Plus- Prem Discount	Employee Only	75089
F	6/7/1985	51793.290	Advantage Plus- Prem Discount	Employee Only	75002
M	10/15/1983	36615.290	Advantage Plus- Prem Discount	Employee Only	75044
M	3/15/1984	36557.620	Advantage Plus- Prem Discount	Employee Only	75409
F	9/21/1955	28004.000	Advantage Plus- Prem Discount	Employee Only	75002
F	11/23/1957	28238.650	Advantage Plus- Prem Discount	Employee Only	75092
M	3/26/1946	26156.770	Advantage Plus- Prem Discount	Employee Only	75424
F	12/22/1983	32640.000	Advantage Plus- Prem Discount	Employee Only	75087
F	2/10/1987	28474.770	Advantage Plus- Prem Discount	Employee Only	75287
F	11/21/1974	28293.610	Advantage Plus- Prem Discount	Employee Only	75070
F	2/8/1959	30369.140	Advantage Plus- Prem Discount	Employee Only	76227
F	6/29/1971	32907.340	Advantage Plus- Prem Discount	Employee Only	75407
M	10/12/1966	36285.690	Advantage Plus- Prem Discount	Employee Only	75071
F	4/24/1983	28004.000	Advantage Plus- Prem Discount	Employee Only	75069
M	8/24/1957	36257.530	Advantage Plus- Prem Discount	Employee Only	75069
F	4/3/1986	36257.530	Advantage Plus- Prem Discount	Employee Only	75409
M	9/21/1990	35723.170	Advantage Plus- Prem Discount	Employee Only	75424
F	7/23/1974	32640.000	Advantage Plus- Prem Discount	Employee Only	75490
F	12/23/1962	32640.000	Advantage Plus- Prem Discount	Employee Only	75070
F	7/28/1955	28004.000	Advantage Plus- Prem Discount	Employee Only	75166
F	11/16/1982	34005.000	Advantage Plus- Prem Discount	Employee Only	75069
F	2/24/1957	28004.070	Advantage Plus- Prem Discount	Employee Only	75070
F	11/5/1971	42680.120	Advantage Plus- Prem Discount	Employee Only	75071
M	6/25/1980	48201.060	Advantage Plus- Prem Discount	Employee Only	75454
M	7/1/1946	28004.000	Advantage Plus- Prem Discount	Employee Only	75074
F	12/28/1951	28004.000	Advantage Plus- Prem Discount	Employee Only	75071
F	5/23/1978	30180.000	Advantage Plus- Prem Discount	Employee Only	75069
F	3/1/1985	30180.000	Advantage Plus- Prem Discount	Employee Only	75048
M	8/11/1977	38446.000	Advantage Plus- Prem Discount	Employee Only	75069
F	5/4/1980	43835.140	Advantage Plus- Prem Discount	Employee Only	75074
F	4/19/1966	30183.710	Advantage Plus- Prem Discount	Employee Only	75069
M	5/19/1951	92454.860	Advantage Plus- Prem Discount	Employee Only	75069
M	1/3/1983	32640.000	Advantage Plus- Prem Discount	Employee Only	75452
F	6/17/1989	32640.000	Advantage Plus- Prem Discount	Employee Only	75459
M	2/19/1990	34943.380	Advantage Plus- Prem Discount	Employee Only	75069
M	7/30/1983	47804.000	Advantage Plus- Prem Discount	Employee Only	75070

Attachment J - Active Employee Medical Census

M	1/18/1991	28004.000	Advantage Plus- Prem Discount	Employee Only	75407
F	9/4/1986	45797.000	Advantage Plus- Prem Discount	Employee Only	75021
F	8/5/1972	28004.000	Advantage Plus- Prem Discount	Employee Only	75423
F	9/26/1973	43270.550	Advantage Plus- Prem Discount	Employee Only	76227
M	2/10/1973	38956.230	Advantage Plus- Prem Discount	Employee Only	75495
F	12/4/1978	28004.000	Advantage Plus- Prem Discount	Employee Only	75035
M	9/2/1969	57237.220	Advantage Plus- Prem Discount	Employee Only	75078
M	8/31/1973	41911.000	Advantage Plus- Prem Discount	Employee Only	75442
M	4/4/1992	34398.900	Advantage Plus- Prem Discount	Employee Only	75074
F	12/11/1950	78022.500	Advantage Plus- Prem Discount	Employee Only	75071
M	7/3/1983	34344.710	Advantage Plus- Prem Discount	Employee Only	75071
M	1/29/1990	34290.510	Advantage Plus- Prem Discount	Employee Only	75040
M	1/19/1982	44463.000	Advantage Plus- Prem Discount	Employee Only	75056
F	7/18/1986	57016.340	Advantage Plus- Prem Discount	Employee Only	75023
F	2/8/1978	29861.390	Advantage Plus- Prem Discount	Employee Only	75409
F	7/7/1986	56608.000	Advantage Plus- Prem Discount	Employee Only	75206
M	4/5/1947	46571.230	Advantage Plus- Prem Discount	Employee Only	75040
F	7/3/1979	34005.980	Advantage Plus- Prem Discount	Employee Only	75407
M	1/14/1969	34005.980	Advantage Plus- Prem Discount	Employee Only	75071
F	11/24/1961	96507.140	Advantage Plus- Prem Discount	Employee Only	76210
M	10/15/1982	41911.000	Advantage Plus- Prem Discount	Employee Only	75071
F	10/26/1978	28004.000	Advantage Plus- Prem Discount	Employee Only	75009
F	1/23/1963	35378.000	Advantage Plus- Prem Discount	Employee Only	75070
F	11/4/1954	30180.000	Advantage Plus- Prem Discount	Employee Only	75409
M	10/18/1960	32640.000	Advantage Plus- Prem Discount	Employee Only	75173
M	2/14/1983	34005.000	Advantage Plus- Prem Discount	Employee Only	75423
F	12/12/1986	55186.000	Advantage Plus- Prem Discount	Employee Only	76227
F	10/9/1962	90110.330	Advantage Plus- Prem Discount	Employee Only	76051
M	5/27/1988	32640.000	Advantage Plus- Prem Discount	Employee Only	75070
F	7/27/1988	56608.000	Advantage Plus- Prem Discount	Employee Only	75067
M	8/28/1984	34005.000	Advantage Plus- Prem Discount	Employee Only	75150
M	5/30/1978	41911.000	Advantage Plus- Prem Discount	Employee Only	75491
M	3/21/1990	34005.000	Advantage Plus- Prem Discount	Employee Only	75070
F	8/6/1971	30996.870	Advantage Plus- Prem Discount	Employee Only	75452
M	1/26/1983	50223.000	Advantage Plus- Prem Discount	Employee Only	75090
F	6/20/1988	34005.000	Advantage Plus- Prem Discount	Employee Only	75098
F	8/1/1985	34005.000	Advantage Plus- Prem Discount	Employee Only	75287
M	1/30/1981	56608.000	Advantage Plus- Prem Discount	Employee Only	75069
M	5/24/1991	34005.000	Advantage Plus- Prem Discount	Employee Only	75071
F	9/12/1958	68638.200	Advantage Plus- Prem Discount	Employee + Spouse	75409
F	2/4/1985	31554.340	Advantage Plus- Prem Discount	Employee + Spouse	75475
F	11/5/1942	57667.180	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	12/26/1945	36427.340	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	3/15/1947	65458.560	Advantage Plus- Prem Discount	Employee + Spouse	76259
M	5/8/1956	48798.130	Advantage Plus- Prem Discount	Employee + Spouse	75074

Attachment J - Active Employee Medical Census

M	3/5/1960	73208.860	Advantage Plus- Prem Discount	Employee + Spouse	75092
M	10/28/1952	44314.660	Advantage Plus- Prem Discount	Employee + Spouse	75442
M	3/3/1950	142955.760	Advantage Plus- Prem Discount	Employee + Spouse	75070
M	5/14/1978	53377.240	Advantage Plus- Prem Discount	Employee + Spouse	75459
F	10/16/1958	47795.350	Advantage Plus- Prem Discount	Employee + Spouse	75002
F	7/18/1965	53500.710	Advantage Plus- Prem Discount	Employee + Spouse	75166
F	6/20/1964	46767.100	Advantage Plus- Prem Discount	Employee + Spouse	75069
M	4/23/1956	62367.850	Advantage Plus- Prem Discount	Employee + Spouse	75423
M	4/18/1963	43970.580	Advantage Plus- Prem Discount	Employee + Spouse	75442
M	9/28/1952	47851.000	Advantage Plus- Prem Discount	Employee + Spouse	75491
M	10/29/1956	92444.560	Advantage Plus- Prem Discount	Employee + Spouse	75442
F	1/14/1970	34775.670	Advantage Plus- Prem Discount	Employee + Spouse	75173
M	1/31/1955	47849.390	Advantage Plus- Prem Discount	Employee + Spouse	75409
F	6/21/1955	33087.260	Advantage Plus- Prem Discount	Employee + Spouse	75069
F	8/2/1950	29094.490	Advantage Plus- Prem Discount	Employee + Spouse	75023
M	1/26/1962	45000.110	Advantage Plus- Prem Discount	Employee + Spouse	76227
F	3/12/1957	39890.180	Advantage Plus- Prem Discount	Employee + Spouse	75491
F	4/15/1956	47849.390	Advantage Plus- Prem Discount	Employee + Spouse	75407
F	4/23/1955	37303.500	Advantage Plus- Prem Discount	Employee + Spouse	75074
F	6/22/1966	39003.620	Advantage Plus- Prem Discount	Employee + Spouse	75438
F	9/19/1958	46530.720	Advantage Plus- Prem Discount	Employee + Spouse	75424
M	4/4/1952	47341.270	Advantage Plus- Prem Discount	Employee + Spouse	75442
F	2/3/1947	40709.960	Advantage Plus- Prem Discount	Employee + Spouse	75069
M	2/25/1963	44314.660	Advantage Plus- Prem Discount	Employee + Spouse	75452
F	1/19/1945	39486.880	Advantage Plus- Prem Discount	Employee + Spouse	75135
M	7/18/1962	81219.560	Advantage Plus- Prem Discount	Employee + Spouse	75490
M	2/14/1981	52648.840	Advantage Plus- Prem Discount	Employee + Spouse	75454
M	11/25/1947	51615.180	Advantage Plus- Prem Discount	Employee + Spouse	75071
M	2/6/1950	88573.970	Advantage Plus- Prem Discount	Employee + Spouse	75082
M	4/25/1969	57593.950	Advantage Plus- Prem Discount	Employee + Spouse	75007
M	12/6/1955	74652.480	Advantage Plus- Prem Discount	Employee + Spouse	75002
F	5/28/1952	40760.670	Advantage Plus- Prem Discount	Employee + Spouse	75097
M	7/15/1952	97334.440	Advantage Plus- Prem Discount	Employee + Spouse	75070
M	5/8/1976	68639.000	Advantage Plus- Prem Discount	Employee + Spouse	75454
F	6/6/1957	47947.850	Advantage Plus- Prem Discount	Employee + Spouse	75442
M	2/15/1952	47849.390	Advantage Plus- Prem Discount	Employee + Spouse	75409
F	9/7/1952	47849.390	Advantage Plus- Prem Discount	Employee + Spouse	75002
F	2/19/1965	114317.640	Advantage Plus- Prem Discount	Employee + Spouse	75070
M	3/17/1952	42986.680	Advantage Plus- Prem Discount	Employee + Spouse	76268
F	2/28/1954	37666.620	Advantage Plus- Prem Discount	Employee + Spouse	75023
M	4/24/1950	97334.440	Advantage Plus- Prem Discount	Employee + Spouse	75013
F	10/2/1954	52440.340	Advantage Plus- Prem Discount	Employee + Spouse	75071
M	9/12/1953	52139.550	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	6/29/1949	73779.780	Advantage Plus- Prem Discount	Employee + Spouse	75090
F	6/12/1953	213339.650	Advantage Plus- Prem Discount	Employee + Spouse	75070

Attachment J - Active Employee Medical Census

M	6/10/1959	47849.390	Advantage Plus- Prem Discount	Employee + Spouse	75459
M	7/1/1947	68638.200	Advantage Plus- Prem Discount	Employee + Spouse	75002
M	6/30/1951	68638.200	Advantage Plus- Prem Discount	Employee + Spouse	75070
F	10/13/1963	47849.390	Advantage Plus- Prem Discount	Employee + Spouse	75070
F	10/24/1955	40696.260	Advantage Plus- Prem Discount	Employee + Spouse	75080
F	4/13/1944	75602.440	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	12/2/1948	63838.130	Advantage Plus- Prem Discount	Employee + Spouse	75418
F	9/18/1956	40827.730	Advantage Plus- Prem Discount	Employee + Spouse	75491
M	3/1/1967	38700.230	Advantage Plus- Prem Discount	Employee + Spouse	75407
M	8/12/1954	44207.080	Advantage Plus- Prem Discount	Employee + Spouse	75442
F	7/31/1952	62073.920	Advantage Plus- Prem Discount	Employee + Spouse	75407
F	11/8/1959	43217.770	Advantage Plus- Prem Discount	Employee + Spouse	75071
M	7/5/1955	62205.730	Advantage Plus- Prem Discount	Employee + Spouse	75490
M	3/27/1970	72070.110	Advantage Plus- Prem Discount	Employee + Spouse	75452
M	5/30/1953	37215.500	Advantage Plus- Prem Discount	Employee + Spouse	75009
F	10/11/1962	40616.660	Advantage Plus- Prem Discount	Employee + Spouse	75495
M	4/16/1957	56756.920	Advantage Plus- Prem Discount	Employee + Spouse	75002
M	4/28/1953	276834.580	Advantage Plus- Prem Discount	Employee + Spouse	75252
M	5/19/1959	62156.980	Advantage Plus- Prem Discount	Employee + Spouse	75020
F	11/5/1980	40041.130	Advantage Plus- Prem Discount	Employee + Spouse	75071
M	6/3/1954	50359.980	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	12/17/1955	105768.310	Advantage Plus- Prem Discount	Employee + Spouse	75442-0106
M	4/11/1948	92444.560	Advantage Plus- Prem Discount	Employee + Spouse	75002
M	1/5/1956	40827.730	Advantage Plus- Prem Discount	Employee + Spouse	75002
F	12/10/1955	48093.030	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	12/14/1959	77910.140	Advantage Plus- Prem Discount	Employee + Spouse	75002
M	7/14/1962	31645.540	Advantage Plus- Prem Discount	Employee + Spouse	75424
M	11/20/1961	87994.350	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	3/10/1954	51699.640	Advantage Plus- Prem Discount	Employee + Spouse	75442
M	9/16/1953	83803.000	Advantage Plus- Prem Discount	Employee + Spouse	75002
M	3/30/1956	48074.890	Advantage Plus- Prem Discount	Employee + Spouse	75442
F	12/3/1949	44239.870	Advantage Plus- Prem Discount	Employee + Spouse	75407
F	10/25/1953	52202.480	Advantage Plus- Prem Discount	Employee + Spouse	75407
F	1/21/1951	44604.440	Advantage Plus- Prem Discount	Employee + Spouse	75002-5075
F	8/31/1962	39996.410	Advantage Plus- Prem Discount	Employee + Spouse	75407
M	4/10/1951	87943.430	Advantage Plus- Prem Discount	Employee + Spouse	75093
F	3/27/1954	50947.820	Advantage Plus- Prem Discount	Employee + Spouse	75002
F	11/25/1959	38032.960	Advantage Plus- Prem Discount	Employee + Spouse	75442
F	4/14/1961	44317.900	Advantage Plus- Prem Discount	Employee + Spouse	75495
M	5/14/1954	44314.660	Advantage Plus- Prem Discount	Employee + Spouse	75002
F	1/17/1950	50461.510	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	4/5/1950	39832.670	Advantage Plus- Prem Discount	Employee + Spouse	75407
F	1/5/1949	54731.060	Advantage Plus- Prem Discount	Employee + Spouse	75075
F	12/26/1960	49755.440	Advantage Plus- Prem Discount	Employee + Spouse	75490
M	4/4/1959	30061.250	Advantage Plus- Prem Discount	Employee + Spouse	75454

Attachment J - Active Employee Medical Census

F	3/7/1949	33084.730	Advantage Plus- Prem Discount	Employee + Spouse	75070
F	5/18/1959	34411.490	Advantage Plus- Prem Discount	Employee + Spouse	75002
M	7/31/1945	64717.300	Advantage Plus- Prem Discount	Employee + Spouse	75071
M	7/22/1952	35830.850	Advantage Plus- Prem Discount	Employee + Spouse	75496
F	3/22/1982	42074.210	Advantage Plus- Prem Discount	Employee + Spouse	75454
M	10/22/1956	81063.860	Advantage Plus- Prem Discount	Employee + Spouse	75078
M	12/13/1951	59265.860	Advantage Plus- Prem Discount	Employee + Spouse	75173
F	10/24/1945	33217.300	Advantage Plus- Prem Discount	Employee + Spouse	75070
F	8/2/1952	35378.000	Advantage Plus- Prem Discount	Employee + Spouse	75076
F	5/21/1982	73560.140	Advantage Plus- Prem Discount	Employee + Spouse	75070
F	1/10/1961	35729.150	Advantage Plus- Prem Discount	Employee + Spouse	75070
F	4/23/1959	28602.000	Advantage Plus- Prem Discount	Employee + Spouse	75023
M	5/7/1951	38283.170	Advantage Plus- Prem Discount	Employee + Spouse	75070
M	2/13/1960	36435.680	Advantage Plus- Prem Discount	Employee + Spouse	75490
F	2/27/1957	28004.000	Advantage Plus- Prem Discount	Employee + Spouse	75070
M	5/21/1959	30481.670	Advantage Plus- Prem Discount	Employee + Spouse	75076
M	12/25/1951	36435.680	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	7/29/1957	32640.000	Advantage Plus- Prem Discount	Employee + Spouse	76227
M	2/1/1961	38956.230	Advantage Plus- Prem Discount	Employee + Spouse	75075
F	12/13/1951	37974.440	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	12/15/1978	38521.050	Advantage Plus- Prem Discount	Employee + Spouse	75409
F	10/10/1951	30183.710	Advantage Plus- Prem Discount	Employee + Spouse	75069
F	12/21/1961	32640.000	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	1/8/1959	111045.960	Advantage Plus- Prem Discount	Employee + Spouse	75080
F	11/24/1964	30222.640	Advantage Plus- Prem Discount	Employee + Spouse	75023
F	8/29/1954	28004.000	Advantage Plus- Prem Discount	Employee + Spouse	75071
F	9/8/1953	30180.000	Advantage Plus- Prem Discount	Employee + Spouse	75070
F	9/9/1965	47049.510	Advantage Plus- Prem Discount	Employee + Spouse	76227
F	11/26/1980	26084.000	Advantage Plus- Prem Discount	Employee + Spouse	75070
M	4/3/1991	34005.000	Advantage Plus- Prem Discount	Employee + Spouse	75402
M	10/14/1971	55186.000	Advantage Plus- Prem Discount	Employee + Spouse	75070
F	8/1/1962	32640.000	Advantage Plus- Prem Discount	Employee + Spouse	75452
M	11/12/1952	62756.000	Advantage Plus- Prem Discount	Employee + Spouse	75002
M	10/28/1985	52226.000	Advantage Plus- Prem Discount	Employee + Spouse	75009
F	10/10/1977	42680.120	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
M	6/29/1968	65769.120	Advantage Plus- Prem Discount	Employee + Child(ren)	75454
F	6/21/1979	37974.840	Advantage Plus- Prem Discount	Employee + Child(ren)	75424
F	1/5/1970	96507.140	Advantage Plus- Prem Discount	Employee + Child(ren)	75094
F	1/24/1974	50548.750	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
M	1/13/1968	59453.660	Advantage Plus- Prem Discount	Employee + Child(ren)	75090
M	5/25/1965	47849.390	Advantage Plus- Prem Discount	Employee + Child(ren)	75150
M	7/28/1964	67703.370	Advantage Plus- Prem Discount	Employee + Child(ren)	75098
F	8/9/1960	49502.430	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	6/14/1973	35581.630	Advantage Plus- Prem Discount	Employee + Child(ren)	75442
F	5/9/1978	56793.330	Advantage Plus- Prem Discount	Employee + Child(ren)	75034

Attachment J - Active Employee Medical Census

F	6/3/1962	52177.410	Advantage Plus- Prem Discount	Employee + Child(ren)	75442
F	6/16/1972	40249.600	Advantage Plus- Prem Discount	Employee + Child(ren)	75069
M	6/19/1959	56979.810	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	10/29/1970	44317.100	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
F	6/10/1974	36872.180	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
F	2/14/1967	47849.390	Advantage Plus- Prem Discount	Employee + Child(ren)	75442
M	7/22/1964	99418.660	Advantage Plus- Prem Discount	Employee + Child(ren)	75013
F	1/25/1969	38450.460	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
M	10/28/1973	66167.900	Advantage Plus- Prem Discount	Employee + Child(ren)	76227
F	1/31/1962	42714.600	Advantage Plus- Prem Discount	Employee + Child(ren)	75074
F	2/13/1959	39530.690	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
M	6/29/1964	44207.080	Advantage Plus- Prem Discount	Employee + Child(ren)	75452
M	7/25/1974	48670.360	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
F	12/8/1974	30330.770	Advantage Plus- Prem Discount	Employee + Child(ren)	75407
M	8/6/1968	61443.900	Advantage Plus- Prem Discount	Employee + Child(ren)	75495
M	5/4/1976	89344.820	Advantage Plus- Prem Discount	Employee + Child(ren)	75454
M	2/6/1978	46157.310	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
F	7/13/1960	40793.890	Advantage Plus- Prem Discount	Employee + Child(ren)	75025
M	10/16/1969	73230.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75021
F	5/18/1979	32727.970	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
F	4/3/1973	68359.140	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
M	8/3/1969	68132.560	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
M	6/22/1975	42723.530	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	8/27/1980	47289.710	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
M	5/3/1967	52700.540	Advantage Plus- Prem Discount	Employee + Child(ren)	75495
M	1/22/1979	54883.810	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
M	2/27/1973	52139.550	Advantage Plus- Prem Discount	Employee + Child(ren)	75002
F	7/30/1980	46158.400	Advantage Plus- Prem Discount	Employee + Child(ren)	75452
F	1/3/1968	39293.140	Advantage Plus- Prem Discount	Employee + Child(ren)	75098
F	7/2/1982	40366.600	Advantage Plus- Prem Discount	Employee + Child(ren)	75452
M	8/8/1970	47849.390	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
M	9/14/1975	46964.960	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
M	9/7/1968	38019.990	Advantage Plus- Prem Discount	Employee + Child(ren)	75442
F	7/10/1973	47849.390	Advantage Plus- Prem Discount	Employee + Child(ren)	75076
F	2/1/1972	52241.030	Advantage Plus- Prem Discount	Employee + Child(ren)	75069
M	9/4/1981	64748.780	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
F	12/8/1973	80251.800	Advantage Plus- Prem Discount	Employee + Child(ren)	75442
F	1/23/1975	66472.850	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	8/5/1957	47849.390	Advantage Plus- Prem Discount	Employee + Child(ren)	75241
F	11/1/1967	41055.500	Advantage Plus- Prem Discount	Employee + Child(ren)	75424
F	3/2/1968	47849.390	Advantage Plus- Prem Discount	Employee + Child(ren)	75002
F	11/17/1965	37760.140	Advantage Plus- Prem Discount	Employee + Child(ren)	75058
F	9/30/1975	73208.860	Advantage Plus- Prem Discount	Employee + Child(ren)	75442
M	8/30/1959	97334.440	Advantage Plus- Prem Discount	Employee + Child(ren)	75009
M	8/31/1968	47849.390	Advantage Plus- Prem Discount	Employee + Child(ren)	75056

Attachment J - Active Employee Medical Census

F	6/21/1974	35785.070	Advantage Plus- Prem Discount	Employee + Child(ren)	75023
M	11/15/1966	73231.040	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	3/8/1976	52268.530	Advantage Plus- Prem Discount	Employee + Child(ren)	75454
F	8/15/1963	46681.630	Advantage Plus- Prem Discount	Employee + Child(ren)	75401
F	5/8/1965	105600.320	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
M	12/16/1965	51242.780	Advantage Plus- Prem Discount	Employee + Child(ren)	75002
F	11/30/1957	43640.960	Advantage Plus- Prem Discount	Employee + Child(ren)	75023
M	6/6/1981	47245.410	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
M	8/9/1970	59453.660	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	3/16/1971	54874.930	Advantage Plus- Prem Discount	Employee + Child(ren)	75495
F	5/25/1984	39088.770	Advantage Plus- Prem Discount	Employee + Child(ren)	75452
M	8/27/1969	47849.390	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	6/26/1960	37569.660	Advantage Plus- Prem Discount	Employee + Child(ren)	75070-4770
F	1/30/1979	37333.490	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
F	11/30/1968	50127.880	Advantage Plus- Prem Discount	Employee + Child(ren)	75495
F	7/31/1969	54931.630	Advantage Plus- Prem Discount	Employee + Child(ren)	75495
F	4/27/1967	37921.830	Advantage Plus- Prem Discount	Employee + Child(ren)	75069
M	8/29/1967	62320.680	Advantage Plus- Prem Discount	Employee + Child(ren)	75495
M	12/23/1978	47494.750	Advantage Plus- Prem Discount	Employee + Child(ren)	75093
M	4/22/1969	54805.010	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
M	9/1/1984	66990.190	Advantage Plus- Prem Discount	Employee + Child(ren)	75454
M	2/26/1963	65631.760	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	2/19/1964	36161.770	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
M	7/18/1973	47849.390	Advantage Plus- Prem Discount	Employee + Child(ren)	75496
M	5/16/1955	59453.660	Advantage Plus- Prem Discount	Employee + Child(ren)	75071-7844
M	5/24/1970	67368.520	Advantage Plus- Prem Discount	Employee + Child(ren)	76201
M	7/30/1970	59648.240	Advantage Plus- Prem Discount	Employee + Child(ren)	75092
F	8/13/1980	56911.520	Advantage Plus- Prem Discount	Employee + Child(ren)	75407
M	6/29/1974	40827.730	Advantage Plus- Prem Discount	Employee + Child(ren)	75090
M	7/5/1953	83804.150	Advantage Plus- Prem Discount	Employee + Child(ren)	75002
M	3/13/1973	42761.540	Advantage Plus- Prem Discount	Employee + Child(ren)	75423
F	10/24/1974	50706.120	Advantage Plus- Prem Discount	Employee + Child(ren)	75093
M	5/22/1973	52149.790	Advantage Plus- Prem Discount	Employee + Child(ren)	75490
M	1/7/1955	73230.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
F	3/22/1966	90406.090	Advantage Plus- Prem Discount	Employee + Child(ren)	75094
F	8/8/1966	45719.300	Advantage Plus- Prem Discount	Employee + Child(ren)	75461
M	6/26/1949	68638.200	Advantage Plus- Prem Discount	Employee + Child(ren)	75009
F	5/7/1968	43289.100	Advantage Plus- Prem Discount	Employee + Child(ren)	75040
M	3/9/1969	55485.020	Advantage Plus- Prem Discount	Employee + Child(ren)	75454
F	6/8/1972	43040.390	Advantage Plus- Prem Discount	Employee + Child(ren)	75454
M	6/26/1973	47849.390	Advantage Plus- Prem Discount	Employee + Child(ren)	75452
F	2/13/1982	45000.110	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	6/18/1972	42582.380	Advantage Plus- Prem Discount	Employee + Child(ren)	75495
F	7/21/1987	34292.330	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
F	1/27/1978	40916.643	Advantage Plus- Prem Discount	Employee + Child(ren)	75409

Attachment J - Active Employee Medical Census

M	9/1/1956	84142.790	Advantage Plus- Prem Discount	Employee + Child(ren)	75069
F	3/3/1977	61562.280	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
F	12/5/1987	26084.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
F	8/1/1969	95539.530	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
M	9/4/1957	67439.520	Advantage Plus- Prem Discount	Employee + Child(ren)	75414
F	8/13/1977	57297.260	Advantage Plus- Prem Discount	Employee + Child(ren)	75409
F	4/16/1980	26084.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
F	9/8/1982	64886.250	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
M	11/14/1968	81782.960	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	4/14/1968	52051.360	Advantage Plus- Prem Discount	Employee + Child(ren)	75025
F	3/14/1980	30274.540	Advantage Plus- Prem Discount	Employee + Child(ren)	75442
F	11/23/1961	40531.480	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	8/16/1974	36907.050	Advantage Plus- Prem Discount	Employee + Child(ren)	76209
M	4/25/1961	49294.040	Advantage Plus- Prem Discount	Employee + Child(ren)	75407
F	11/15/1981	39926.680	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
F	12/23/1963	36795.440	Advantage Plus- Prem Discount	Employee + Child(ren)	75491
F	2/21/1960	30872.480	Advantage Plus- Prem Discount	Employee + Child(ren)	75452
F	6/6/1956	60840.950	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
M	11/12/1983	30683.210	Advantage Plus- Prem Discount	Employee + Child(ren)	75458
F	6/25/1983	73986.380	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
F	7/17/1982	28321.540	Advantage Plus- Prem Discount	Employee + Child(ren)	75056
F	11/3/1981	45021.850	Advantage Plus- Prem Discount	Employee + Child(ren)	75454
M	1/14/1983	72984.030	Advantage Plus- Prem Discount	Employee + Child(ren)	75206
F	12/16/1956	55248.250	Advantage Plus- Prem Discount	Employee + Child(ren)	75454
F	12/17/1980	32975.110	Advantage Plus- Prem Discount	Employee + Child(ren)	75407
F	8/25/1977	38195.890	Advantage Plus- Prem Discount	Employee + Child(ren)	75287
F	6/26/1981	51564.828	Advantage Plus- Prem Discount	Employee + Child(ren)	75034
F	12/2/1957	32714.690	Advantage Plus- Prem Discount	Employee + Child(ren)	75002
F	6/10/1965	38956.230	Advantage Plus- Prem Discount	Employee + Child(ren)	75070
F	3/7/1955	33835.600	Advantage Plus- Prem Discount	Employee + Child(ren)	75034
F	4/16/1981	32673.870	Advantage Plus- Prem Discount	Employee + Child(ren)	75069
M	2/26/1971	91481.019	Advantage Plus- Prem Discount	Employee + Child(ren)	75022
M	12/23/1980	67190.940	Advantage Plus- Prem Discount	Employee + Child(ren)	75454
F	3/12/1987	30180.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75407
F	9/20/1976	32900.330	Advantage Plus- Prem Discount	Employee + Child(ren)	75071
M	11/19/1971	73278.650	Advantage Plus- Prem Discount	Employee + Child(ren)	75087
M	11/30/1970	32640.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75424
M	3/11/1971	41911.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75252
M	9/23/1972	38926.600	Advantage Plus- Prem Discount	Employee + Child(ren)	75115
F	6/30/1990	34005.980	Advantage Plus- Prem Discount	Employee + Child(ren)	75074
F	4/24/1959	32640.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75023
M	11/24/1977	34005.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75428
F	10/10/1969	35378.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75454
F	12/19/1985	34005.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75240
F	12/2/1976	30180.000	Advantage Plus- Prem Discount	Employee + Child(ren)	75070

Attachment J - Active Employee Medical Census

F	11/15/1968	65267.420	Advantage Plus- Prem Discount	Employee + Family	75459
F	8/19/1963	40746.230	Advantage Plus- Prem Discount	Employee + Family	75069
M	12/17/1965	47231.690	Advantage Plus- Prem Discount	Employee + Family	75071
M	2/5/1970	68212.710	Advantage Plus- Prem Discount	Employee + Family	75490
M	3/31/1977	68638.200	Advantage Plus- Prem Discount	Employee + Family	75409
F	12/24/1965	36289.630	Advantage Plus- Prem Discount	Employee + Family	75010
F	8/27/1975	113171.390	Advantage Plus- Prem Discount	Employee + Family	75070-9455
M	10/17/1961	66638.000	Advantage Plus- Prem Discount	Employee + Family	75098
M	1/31/1975	58714.150	Advantage Plus- Prem Discount	Employee + Family	75418
M	7/13/1963	44370.600	Advantage Plus- Prem Discount	Employee + Family	75068
M	3/31/1965	223157.000	Advantage Plus- Prem Discount	Employee + Family	75070
F	9/29/1954	95582.910	Advantage Plus- Prem Discount	Employee + Family	75044
M	4/1/1964	73231.040	Advantage Plus- Prem Discount	Employee + Family	75173
F	9/27/1964	131320.400	Advantage Plus- Prem Discount	Employee + Family	75021
M	11/26/1982	56761.750	Advantage Plus- Prem Discount	Employee + Family	75495
F	9/27/1966	39541.520	Advantage Plus- Prem Discount	Employee + Family	75452
M	9/6/1969	73231.040	Advantage Plus- Prem Discount	Employee + Family	75070
F	5/14/1968	67742.990	Advantage Plus- Prem Discount	Employee + Family	75013
F	9/10/1957	48104.910	Advantage Plus- Prem Discount	Employee + Family	75424
M	11/24/1968	76892.590	Advantage Plus- Prem Discount	Employee + Family	75009
M	1/29/1953	72255.460	Advantage Plus- Prem Discount	Employee + Family	75080-4917
M	8/11/1955	37214.280	Advantage Plus- Prem Discount	Employee + Family	75442
F	2/14/1969	39921.660	Advantage Plus- Prem Discount	Employee + Family	75495
M	9/7/1979	38461.800	Advantage Plus- Prem Discount	Employee + Family	75442
F	6/7/1968	39631.330	Advantage Plus- Prem Discount	Employee + Family	75495
F	10/28/1967	47739.220	Advantage Plus- Prem Discount	Employee + Family	75409
M	3/30/1978	68638.200	Advantage Plus- Prem Discount	Employee + Family	75409
M	2/2/1968	68638.200	Advantage Plus- Prem Discount	Employee + Family	75070
M	1/17/1978	43660.520	Advantage Plus- Prem Discount	Employee + Family	75088
M	6/1/1983	53819.020	Advantage Plus- Prem Discount	Employee + Family	75409
F	2/23/1966	45881.590	Advantage Plus- Prem Discount	Employee + Family	75442
M	4/25/1968	72202.030	Advantage Plus- Prem Discount	Employee + Family	75098
M	7/5/1972	42834.730	Advantage Plus- Prem Discount	Employee + Family	75409
M	7/20/1980	47849.390	Advantage Plus- Prem Discount	Employee + Family	76227
M	8/15/1967	42779.550	Advantage Plus- Prem Discount	Employee + Family	75020
M	2/7/1971	56660.610	Advantage Plus- Prem Discount	Employee + Family	75206
M	5/8/1972	47849.390	Advantage Plus- Prem Discount	Employee + Family	75424
M	9/5/1982	47849.390	Advantage Plus- Prem Discount	Employee + Family	75409
M	11/17/1973	58702.770	Advantage Plus- Prem Discount	Employee + Family	75070
F	4/29/1969	90989.510	Advantage Plus- Prem Discount	Employee + Family	75409
M	3/2/1956	126733.900	Advantage Plus- Prem Discount	Employee + Family	75025
F	4/27/1959	39289.960	Advantage Plus- Prem Discount	Employee + Family	75495
M	6/30/1965	65342.050	Advantage Plus- Prem Discount	Employee + Family	75035
M	1/19/1956	52503.810	Advantage Plus- Prem Discount	Employee + Family	75070
M	1/15/1970	65763.130	Advantage Plus- Prem Discount	Employee + Family	75070

Attachment J - Active Employee Medical Census

F	11/4/1954	67408.150	Advantage Plus- Prem Discount	Employee + Family	75007
F	8/16/1960	52191.770	Advantage Plus- Prem Discount	Employee + Family	75424
M	5/24/1956	59415.020	Advantage Plus- Prem Discount	Employee + Family	75070
F	11/7/1978	48903.790	Advantage Plus- Prem Discount	Employee + Family	75409
M	8/12/1968	83804.150	Advantage Plus- Prem Discount	Employee + Family	75071
M	1/28/1970	47849.390	Advantage Plus- Prem Discount	Employee + Family	75459
M	7/6/1979	79122.250	Advantage Plus- Prem Discount	Employee + Family	75229
F	12/30/1979	38726.880	Advantage Plus- Prem Discount	Employee + Family	75069
F	7/28/1985	31741.010	Advantage Plus- Prem Discount	Employee + Family	75407
M	7/31/1982	54667.430	Advantage Plus- Prem Discount	Employee + Family	75409
M	10/7/1983	55435.190	Advantage Plus- Prem Discount	Employee + Family	75070
M	5/28/1976	58823.250	Advantage Plus- Prem Discount	Employee + Family	75424
M	8/28/1963	44191.070	Advantage Plus- Prem Discount	Employee + Family	75070
M	11/10/1972	73231.040	Advantage Plus- Prem Discount	Employee + Family	75034
F	4/28/1965	66209.460	Advantage Plus- Prem Discount	Employee + Family	75070
M	7/25/1973	47377.810	Advantage Plus- Prem Discount	Employee + Family	75407
F	8/24/1967	44510.970	Advantage Plus- Prem Discount	Employee + Family	75407
M	1/25/1967	78050.090	Advantage Plus- Prem Discount	Employee + Family	76227
M	9/16/1959	47849.000	Advantage Plus- Prem Discount	Employee + Family	75495-2133
F	5/16/1953	37696.270	Advantage Plus- Prem Discount	Employee + Family	75402
F	5/8/1962	168670.830	Advantage Plus- Prem Discount	Employee + Family	75074
F	1/26/1973	35059.370	Advantage Plus- Prem Discount	Employee + Family	75023
F	7/10/1975	89515.250	Advantage Plus- Prem Discount	Employee + Family	75035
M	12/26/1976	55517.000	Advantage Plus- Prem Discount	Employee + Family	75454
M	5/20/1980	43324.930	Advantage Plus- Prem Discount	Employee + Family	75020
M	5/15/1979	46903.890	Advantage Plus- Prem Discount	Employee + Family	75020
F	12/30/1972	40395.810	Advantage Plus- Prem Discount	Employee + Family	75491
M	7/17/1980	39524.360	Advantage Plus- Prem Discount	Employee + Family	75071
M	3/20/1957	143725.920	Advantage Plus- Prem Discount	Employee + Family	75070
F	3/29/1964	42341.370	Advantage Plus- Prem Discount	Employee + Family	75002
M	10/10/1982	58702.770	Advantage Plus- Prem Discount	Employee + Family	75479
F	2/10/1963	56953.860	Advantage Plus- Prem Discount	Employee + Family	75071
F	8/6/1971	57746.220	Advantage Plus- Prem Discount	Employee + Family	75071
M	5/27/1972	94281.450	Advantage Plus- Prem Discount	Employee + Family	75013
M	3/14/1975	52043.330	Advantage Plus- Prem Discount	Employee + Family	75477
M	5/24/1968	73232.000	Advantage Plus- Prem Discount	Employee + Family	75098
M	6/4/1979	73231.040	Advantage Plus- Prem Discount	Employee + Family	75071
M	12/30/1977	64717.300	Advantage Plus- Prem Discount	Employee + Family	75409
M	12/13/1975	47849.390	Advantage Plus- Prem Discount	Employee + Family	75098
M	8/10/1969	68638.200	Advantage Plus- Prem Discount	Employee + Family	75071
F	2/23/1976	38446.000	Advantage Plus- Prem Discount	Employee + Family	75023
F	8/7/1961	52043.330	Advantage Plus- Prem Discount	Employee + Family	75070
M	8/21/1949	83804.150	Advantage Plus- Prem Discount	Employee + Family	75098
M	8/13/1974	68638.200	Advantage Plus- Prem Discount	Employee + Family	75409
F	9/22/1960	38446.000	Advantage Plus- Prem Discount	Employee + Family	75002

Attachment J - Active Employee Medical Census

M	9/5/1966	52196.060	Advantage Plus- Prem Discount	Employee + Family	75409
M	4/26/1984	54329.450	Advantage Plus- Prem Discount	Employee + Family	75454
M	2/12/1980	76892.740	Advantage Plus- Prem Discount	Employee + Family	75409
F	11/15/1970	31327.240	Advantage Plus- Prem Discount	Employee + Family	75098
M	7/23/1956	87994.350	Advantage Plus- Prem Discount	Employee + Family	75409
F	4/29/1976	40989.160	Advantage Plus- Prem Discount	Employee + Family	75424
F	10/7/1976	52988.135	Advantage Plus- Prem Discount	Employee + Family	75424
M	10/15/1964	56409.060	Advantage Plus- Prem Discount	Employee + Family	75491
M	9/11/1970	73231.040	Advantage Plus- Prem Discount	Employee + Family	75424
M	1/6/1973	78819.420	Advantage Plus- Prem Discount	Employee + Family	75035
M	4/6/1970	45493.950	Advantage Plus- Prem Discount	Employee + Family	75424
M	10/25/1955	56093.640	Advantage Plus- Prem Discount	Employee + Family	75056
M	5/20/1977	68258.170	Advantage Plus- Prem Discount	Employee + Family	75071
F	2/22/1960	48282.290	Advantage Plus- Prem Discount	Employee + Family	75442
M	7/7/1963	73232.000	Advantage Plus- Prem Discount	Employee + Family	75442
M	5/26/1981	68238.000	Advantage Plus- Prem Discount	Employee + Family	75454
M	12/26/1969	76113.000	Advantage Plus- Prem Discount	Employee + Family	75069
F	8/2/1977	56753.020	Advantage Plus- Prem Discount	Employee + Family	75495
F	4/15/1972	60071.690	Advantage Plus- Prem Discount	Employee + Family	75442
F	7/29/1972	37982.730	Advantage Plus- Prem Discount	Employee + Family	75074
M	3/6/1975	84767.140	Advantage Plus- Prem Discount	Employee + Family	75071
M	4/23/1953	135592.480	Advantage Plus- Prem Discount	Employee + Family	75070
M	6/8/1973	53819.020	Advantage Plus- Prem Discount	Employee + Family	75442
M	9/16/1982	47245.970	Advantage Plus- Prem Discount	Employee + Family	75459
M	12/19/1977	42292.010	Advantage Plus- Prem Discount	Employee + Family	75490
M	4/29/1980	68638.200	Advantage Plus- Prem Discount	Employee + Family	75071
M	8/16/1977	50536.690	Advantage Plus- Prem Discount	Employee + Family	75454
M	1/7/1969	87994.350	Advantage Plus- Prem Discount	Employee + Family	75442
M	1/22/1963	57864.960	Advantage Plus- Prem Discount	Employee + Family	75070
M	12/24/1961	83320.450	Advantage Plus- Prem Discount	Employee + Family	75442
M	11/14/1962	68637.140	Advantage Plus- Prem Discount	Employee + Family	75454
M	3/14/1975	68638.200	Advantage Plus- Prem Discount	Employee + Family	75409
M	4/29/1978	55828.840	Advantage Plus- Prem Discount	Employee + Family	75409
M	10/10/1970	54848.780	Advantage Plus- Prem Discount	Employee + Family	75094
M	11/21/1960	64572.060	Advantage Plus- Prem Discount	Employee + Family	75075
M	9/4/1963	34005.980	Advantage Plus- Prem Discount	Employee + Family	75075
M	2/2/1967	131688.920	Advantage Plus- Prem Discount	Employee + Family	75093
M	11/22/1961	39929.250	Advantage Plus- Prem Discount	Employee + Family	75407
M	6/6/1970	153693.000	Advantage Plus- Prem Discount	Employee + Family	75078
M	8/1/1977	40200.430	Advantage Plus- Prem Discount	Employee + Family	75020
M	1/24/1981	40086.910	Advantage Plus- Prem Discount	Employee + Family	75070
M	6/9/1965	36619.480	Advantage Plus- Prem Discount	Employee + Family	75489
M	4/20/1964	42410.940	Advantage Plus- Prem Discount	Employee + Family	76227
F	7/23/1974	28081.490	Advantage Plus- Prem Discount	Employee + Family	75090
M	1/19/1978	40009.230	Advantage Plus- Prem Discount	Employee + Family	75414

Attachment J - Active Employee Medical Census

M	1/20/1970	100515.490	Advantage Plus- Prem Discount	Employee + Family	75070
M	2/24/1987	37114.040	Advantage Plus- Prem Discount	Employee + Family	75491
M	7/9/1977	47324.970	Advantage Plus- Prem Discount	Employee + Family	75424
F	8/21/1970	37114.040	Advantage Plus- Prem Discount	Employee + Family	75069
M	12/27/1970	38225.560	Advantage Plus- Prem Discount	Employee + Family	75088
M	3/29/1981	53819.020	Advantage Plus- Prem Discount	Employee + Family	75002
M	12/20/1971	46641.920	Advantage Plus- Prem Discount	Employee + Family	75092
F	4/1/1966	26936.280	Advantage Plus- Prem Discount	Employee + Family	75452
F	9/25/1970	57036.760	Advantage Plus- Prem Discount	Employee + Family	76210
F	1/9/1983	33301.280	Advantage Plus- Prem Discount	Employee + Family	75409
M	9/9/1970	38953.120	Advantage Plus- Prem Discount	Employee + Family	75454
M	2/3/1982	39088.060	Advantage Plus- Prem Discount	Employee + Family	75071
M	1/15/1968	39088.060	Advantage Plus- Prem Discount	Employee + Family	75071
F	1/21/1988	45797.000	Advantage Plus- Prem Discount	Employee + Family	75407
M	6/8/1967	63543.850	Advantage Plus- Prem Discount	Employee + Family	75070
F	5/18/1957	26795.550	Advantage Plus- Prem Discount	Employee + Family	75071
M	9/10/1971	58763.740	Advantage Plus- Prem Discount	Employee + Family	75009
F	10/14/1962	98352.790	Advantage Plus- Prem Discount	Employee + Family	75069
M	6/13/1961	32974.450	Advantage Plus- Prem Discount	Employee + Family	75071
F	5/10/1952	41926.240	Advantage Plus- Prem Discount	Employee + Family	75075-2041
F	10/17/1966	64978.970	Advantage Plus- Prem Discount	Employee + Family	75071
F	4/11/1984	51317.170	Advantage Plus- Prem Discount	Employee + Family	75407
M	1/5/1979	38654.610	Advantage Plus- Prem Discount	Employee + Family	75021
F	6/8/1967	59329.450	Advantage Plus- Prem Discount	Employee + Family	75035
F	1/11/1959	42158.180	Advantage Plus- Prem Discount	Employee + Family	75013
F	7/18/1972	38452.580	Advantage Plus- Prem Discount	Employee + Family	75071
F	7/27/1969	45797.000	Advantage Plus- Prem Discount	Employee + Family	75150
F	2/21/1976	32640.000	Advantage Plus- Prem Discount	Employee + Family	75013
F	7/29/1983	45030.340	Advantage Plus- Prem Discount	Employee + Family	75409
M	4/20/1958	72624.000	Advantage Plus- Prem Discount	Employee + Family	75002
F	10/14/1985	32721.400	Advantage Plus- Prem Discount	Employee + Family	75452
M	10/2/1984	37149.320	Advantage Plus- Prem Discount	Employee + Family	75407
M	9/1/1990	35380.060	Advantage Plus- Prem Discount	Employee + Family	75407
M	3/18/1977	53161.610	Advantage Plus- Prem Discount	Employee + Family	75094
F	4/30/1956	36694.860	Advantage Plus- Prem Discount	Employee + Family	75407
M	5/25/1990	32640.000	Advantage Plus- Prem Discount	Employee + Family	75071
M	6/23/1968	55105.550	Advantage Plus- Prem Discount	Employee + Family	75071
F	8/4/1972	35594.220	Advantage Plus- Prem Discount	Employee + Family	75098
M	12/4/1958	54700.960	Advantage Plus- Prem Discount	Employee + Family	75166
M	8/31/1974	32640.000	Advantage Plus- Prem Discount	Employee + Family	75442
F	10/18/1980	55186.000	Advantage Plus- Prem Discount	Employee + Family	75454
F	3/21/1971	28004.000	Advantage Plus- Prem Discount	Employee + Family	75098
F	3/2/1984	32686.640	Advantage Plus- Prem Discount	Employee + Family	75071
M	4/12/1989	34344.710	Advantage Plus- Prem Discount	Employee + Family	75071
M	7/29/1976	54382.190	Advantage Plus- Prem Discount	Employee + Family	75035

Attachment J - Active Employee Medical Census

F	12/9/1957	35378.000	Advantage Plus- Prem Discount	Employee + Family	75070
M	11/1/1973	49605.570	Advantage Plus- Prem Discount	Employee + Family	75452
M	6/28/1986	34005.000	Advantage Plus- Prem Discount	Employee + Family	75098
M	3/12/1974	35378.000	Advantage Plus- Prem Discount	Employee + Family	75452
F	7/28/1971	35378.000	Advantage Plus- Prem Discount	Employee + Family	75009
M	8/11/1961	30180.000	Advantage Plus- Prem Discount	Employee + Family	75090
M	5/3/1984	30180.000	Advantage Plus- Prem Discount	Employee + Family	75407
M	10/18/1955	62156.980	Advantage Plus- Prem Surcharge	Employee Only	75090
F	2/2/1967	39392.650	Advantage Plus- Prem Surcharge	Employee Only	75407
F	9/26/1954	45000.110	Advantage Plus- Prem Surcharge	Employee Only	75069
M	5/15/1973	54953.920	Advantage Plus- Prem Surcharge	Employee Only	75071
M	1/5/1962	83804.300	Advantage Plus- Prem Surcharge	Employee Only	75006
M	3/30/1947	67626.170	Advantage Plus- Prem Surcharge	Employee Only	75069
M	5/20/1971	42849.950	Advantage Plus- Prem Surcharge	Employee Only	75070
F	4/20/1959	66166.240	Advantage Plus- Prem Surcharge	Employee Only	75407
F	1/27/1969	57060.470	Advantage Plus- Prem Surcharge	Employee Only	75475
F	3/11/1953	54955.800	Advantage Plus- Prem Surcharge	Employee Only	75071
F	6/22/1953	48200.220	Advantage Plus- Prem Surcharge	Employee Only	75069
M	8/3/1969	55435.190	Advantage Plus- Prem Surcharge	Employee Only	75002
M	6/14/1985	51231.000	Advantage Plus- Prem Surcharge	Employee Only	75069
F	3/16/1950	39837.980	Advantage Plus- Prem Surcharge	Employee Only	75495
M	6/29/1978	40878.170	Advantage Plus- Prem Surcharge	Employee Only	75071
M	1/12/1958	47849.390	Advantage Plus- Prem Surcharge	Employee Only	75090
F	5/31/1972	93382.220	Advantage Plus- Prem Surcharge	Employee Only	75252
M	2/19/1965	47849.390	Advantage Plus- Prem Surcharge	Employee Only	75020
M	5/29/1974	59569.760	Advantage Plus- Prem Surcharge	Employee Only	75078
F	4/30/1966	42931.800	Advantage Plus- Prem Surcharge	Employee Only	75424
M	6/14/1965	43950.180	Advantage Plus- Prem Surcharge	Employee Only	75009
M	8/9/1962	68638.200	Advantage Plus- Prem Surcharge	Employee Only	75070
F	5/18/1943	41924.950	Advantage Plus- Prem Surcharge	Employee Only	75070
F	11/8/1955	93044.030	Advantage Plus- Prem Surcharge	Employee Only	75044
M	1/28/1986	51231.960	Advantage Plus- Prem Surcharge	Employee Only	75070
M	3/4/1970	73231.040	Advantage Plus- Prem Surcharge	Employee Only	75093
F	2/21/1971	94167.910	Advantage Plus- Prem Surcharge	Employee Only	75071
M	10/26/1958	47849.390	Advantage Plus- Prem Surcharge	Employee Only	75409
F	11/25/1950	52698.230	Advantage Plus- Prem Surcharge	Employee Only	75070
M	8/25/1985	31848.300	Advantage Plus- Prem Surcharge	Employee Only	75069
F	7/21/1952	32253.620	Advantage Plus- Prem Surcharge	Employee Only	75081
M	12/6/1963	92454.860	Advantage Plus- Prem Surcharge	Employee Only	75070
M	2/16/1949	39088.060	Advantage Plus- Prem Surcharge	Employee Only	75071
M	5/20/1957	39623.800	Advantage Plus- Prem Surcharge	Employee Only	75020
F	3/7/1986	30701.800	Advantage Plus- Prem Surcharge	Employee Only	75023
F	11/18/1981	30180.000	Advantage Plus- Prem Surcharge	Employee Only	75023
F	7/10/1970	36672.940	Advantage Plus- Prem Surcharge	Employee Only	75407
M	12/26/1962	26280.380	Advantage Plus- Prem Surcharge	Employee Only	75001

Attachment J - Active Employee Medical Census

F	5/22/1990	38956.000	Advantage Plus- Prem Surcharge	Employee Only	75002
F	4/17/1951	30180.000	Advantage Plus- Prem Surcharge	Employee Only	75409
F	6/25/1991	32640.000	Advantage Plus- Prem Surcharge	Employee Only	75401
M	5/12/1986	51005.360	Advantage Plus- Prem Surcharge	Employee Only	75454
M	1/30/1987	57820.000	Advantage Plus- Prem Surcharge	Employee Only	75070
F	11/23/1984	67382.930	Advantage Plus- Prem Surcharge	Employee Only	75206
M	2/17/1982	35380.060	Advantage Plus- Prem Surcharge	Employee Only	75020
M	3/8/1990	34683.450	Advantage Plus- Prem Surcharge	Employee Only	75407
M	5/1/1983	34683.450	Advantage Plus- Prem Surcharge	Employee Only	75069
M	7/20/1990	34683.450	Advantage Plus- Prem Surcharge	Employee Only	75089
F	3/13/1955	26084.000	Advantage Plus- Prem Surcharge	Employee Only	75002
F	10/6/1973	30180.500	Advantage Plus- Prem Surcharge	Employee Only	75090
M	1/20/1987	34629.240	Advantage Plus- Prem Surcharge	Employee Only	75496
F	10/27/1957	30180.500	Advantage Plus- Prem Surcharge	Employee Only	75409
F	11/6/1989	36118.070	Advantage Plus- Prem Surcharge	Employee Only	75491
F	2/25/1958	26120.540	Advantage Plus- Prem Surcharge	Employee Only	75002
M	2/17/1987	34005.000	Advantage Plus- Prem Surcharge	Employee Only	75067
M	3/30/1971	32640.000	Advantage Plus- Prem Surcharge	Employee Only	75069
F	10/2/1989	34005.000	Advantage Plus- Prem Surcharge	Employee Only	75074
M	12/29/1980	39192.000	Advantage Plus- Prem Surcharge	Employee Only	75071
M	3/7/1989	34005.000	Advantage Plus- Prem Surcharge	Employee Only	75173
M	5/5/1950	92454.860	Advantage Plus- Prem Surcharge	Employee + Spouse	75442
F	11/11/1961	36729.150	Advantage Plus- Prem Surcharge	Employee + Spouse	75048
M	4/4/1956	44314.660	Advantage Plus- Prem Surcharge	Employee + Spouse	75452
M	10/22/1962	44771.740	Advantage Plus- Prem Surcharge	Employee + Spouse	75442
F	6/15/1950	46865.930	Advantage Plus- Prem Surcharge	Employee + Spouse	75075
F	11/20/1954	44317.100	Advantage Plus- Prem Surcharge	Employee + Spouse	75090
M	1/11/1973	83352.130	Advantage Plus- Prem Surcharge	Employee + Spouse	75069
F	11/11/1958	33398.200	Advantage Plus- Prem Surcharge	Employee + Spouse	75069
M	1/8/1955	44314.660	Advantage Plus- Prem Surcharge	Employee + Spouse	75490
F	1/7/1962	36351.320	Advantage Plus- Prem Surcharge	Employee + Spouse	75454
F	10/7/1964	47224.100	Advantage Plus- Prem Surcharge	Employee + Spouse	75407
M	6/10/1964	47849.390	Advantage Plus- Prem Surcharge	Employee + Spouse	75070
M	11/14/1944	33582.150	Advantage Plus- Prem Surcharge	Employee + Spouse	75009
M	8/10/1954	80936.970	Advantage Plus- Prem Surcharge	Employee + Spouse	75423
F	7/6/1950	44625.940	Advantage Plus- Prem Surcharge	Employee + Spouse	75069
M	9/8/1952	44284.910	Advantage Plus- Prem Surcharge	Employee + Spouse	75407
F	6/9/1958	56095.000	Advantage Plus- Prem Surcharge	Employee + Spouse	75409
M	12/22/1938	113037.350	Advantage Plus- Prem Surcharge	Employee + Spouse	75069
M	9/18/1960	44314.660	Advantage Plus- Prem Surcharge	Employee + Spouse	75424
M	10/27/1944	95582.890	Advantage Plus- Prem Surcharge	Employee + Spouse	75088
F	8/28/1951	43326.320	Advantage Plus- Prem Surcharge	Employee + Spouse	75452
F	1/5/1947	46169.660	Advantage Plus- Prem Surcharge	Employee + Spouse	75409
F	8/9/1963	32899.690	Advantage Plus- Prem Surcharge	Employee + Spouse	75069
M	10/20/1956	47971.270	Advantage Plus- Prem Surcharge	Employee + Spouse	75490

Attachment J - Active Employee Medical Census

M	3/16/1947	48723.620	Advantage Plus- Prem Surcharge	Employee + Spouse	74701
M	5/3/1941	40490.830	Advantage Plus- Prem Surcharge	Employee + Spouse	75074
F	3/29/1974	78674.670	Advantage Plus- Prem Surcharge	Employee + Spouse	75035
F	5/4/1985	33263.040	Advantage Plus- Prem Surcharge	Employee + Spouse	75452
M	11/1/1984	37016.550	Advantage Plus- Prem Surcharge	Employee + Spouse	75409
M	3/13/1976	26342.080	Advantage Plus- Prem Surcharge	Employee + Spouse	75070
F	9/18/1961	30939.060	Advantage Plus- Prem Surcharge	Employee + Spouse	75452
M	7/31/1955	40539.400	Advantage Plus- Prem Surcharge	Employee + Spouse	75020
F	3/16/1955	55186.000	Advantage Plus- Prem Surcharge	Employee + Spouse	75070
M	10/17/1961	28004.000	Advantage Plus- Prem Surcharge	Employee + Spouse	75424
M	7/31/1974	67920.150	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75424
M	12/26/1975	47849.390	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75071
F	3/28/1975	52139.550	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75070
M	10/18/1982	40827.730	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75002
M	6/13/1973	47849.390	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75442
M	11/23/1975	58409.621	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75407
F	12/5/1975	95583.680	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75454
M	10/8/1972	47826.890	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75070
F	11/5/1971	44488.830	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75097
M	11/24/1962	68638.200	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75071
F	7/26/1957	47849.390	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75409
F	3/11/1963	34658.060	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75074
F	7/4/1967	65312.390	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75173
F	12/4/1963	95583.680	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75025
M	12/11/1952	92444.560	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75070
F	11/7/1972	38993.882	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75071
M	9/3/1960	153693.000	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75071
F	8/25/1988	34514.080	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75454
F	6/19/1985	28004.000	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75454
F	11/28/1964	32640.180	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75058
F	12/3/1984	39918.390	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75002
F	10/22/1978	38446.000	Advantage Plus- Prem Surcharge	Employee + Child(ren)	75089
F	12/12/1981	40343.270	Advantage Plus- Prem Surcharge	Employee + Family	75097
M	5/13/1952	123161.000	Advantage Plus- Prem Surcharge	Employee + Family	75070
F	3/4/1978	45000.110	Advantage Plus- Prem Surcharge	Employee + Family	75409
M	8/4/1963	83804.150	Advantage Plus- Prem Surcharge	Employee + Family	75409
F	2/10/1973	49499.260	Advantage Plus- Prem Surcharge	Employee + Family	75495
M	8/28/1968	58702.770	Advantage Plus- Prem Surcharge	Employee + Family	75069
M	11/11/1955	73231.040	Advantage Plus- Prem Surcharge	Employee + Family	75032
M	1/27/1979	55915.570	Advantage Plus- Prem Surcharge	Employee + Family	75071
M	10/26/1962	66638.000	Advantage Plus- Prem Surcharge	Employee + Family	75458
F	5/22/1973	38399.050	Advantage Plus- Prem Surcharge	Employee + Family	75023
M	11/13/1972	52257.200	Advantage Plus- Prem Surcharge	Employee + Family	75070
F	12/9/1963	32192.390	Advantage Plus- Prem Surcharge	Employee + Family	75173
M	2/21/1974	47849.390	Advantage Plus- Prem Surcharge	Employee + Family	75035

Attachment J - Active Employee Medical Census

F	3/31/1978	47849.390	Advantage Plus- Prem Surcharge	Employee + Family	75092
M	3/20/1973	68638.200	Advantage Plus- Prem Surcharge	Employee + Family	75458
M	5/21/1966	47793.640	Advantage Plus- Prem Surcharge	Employee + Family	75090
M	10/22/1969	84212.730	Advantage Plus- Prem Surcharge	Employee + Family	75402
M	4/16/1977	50241.860	Advantage Plus- Prem Surcharge	Employee + Family	75166
M	8/2/1978	35831.390	Advantage Plus- Prem Surcharge	Employee + Family	75409
M	11/18/1976	73505.890	Advantage Plus- Prem Surcharge	Employee + Family	75442
M	3/1/1975	72070.950	Advantage Plus- Prem Surcharge	Employee + Family	75071
M	11/4/1979	40788.760	Advantage Plus- Prem Surcharge	Employee + Family	75070
M	11/13/1980	47849.000	Advantage Plus- Prem Surcharge	Employee + Family	75409
M	8/9/1970	47849.390	Advantage Plus- Prem Surcharge	Employee + Family	75069
M	4/15/1956	122575.670	Advantage Plus- Prem Surcharge	Employee + Family	75071
M	8/29/1953	90502.830	Advantage Plus- Prem Surcharge	Employee + Family	75040
M	11/2/1967	65260.950	Advantage Plus- Prem Surcharge	Employee + Family	75423
F	7/13/1952	96507.140	Advantage Plus- Prem Surcharge	Employee + Family	75025
M	12/29/1979	47849.390	Advantage Plus- Prem Surcharge	Employee + Family	75080
F	5/9/1959	153693.000	Advantage Plus- Prem Surcharge	Employee + Family	75082
M	6/3/1979	54276.400	Advantage Plus- Prem Surcharge	Employee + Family	75454
M	8/20/1965	49987.220	Advantage Plus- Prem Surcharge	Employee + Family	75458
M	12/31/1974	83804.150	Advantage Plus- Prem Surcharge	Employee + Family	75409
M	12/23/1967	102108.620	Advantage Plus- Prem Surcharge	Employee + Family	75040
M	1/23/1972	102444.560	Advantage Plus- Prem Surcharge	Employee + Family	75002
M	10/3/1961	102444.560	Advantage Plus- Prem Surcharge	Employee + Family	75070
M	12/12/1969	63606.270	Advantage Plus- Prem Surcharge	Employee + Family	75071
M	12/2/1963	68638.200	Advantage Plus- Prem Surcharge	Employee + Family	75424
M	5/29/1961	66638.000	Advantage Plus- Prem Surcharge	Employee + Family	75166
M	10/15/1984	44992.430	Advantage Plus- Prem Surcharge	Employee + Family	75069
M	4/23/1969	40977.530	Advantage Plus- Prem Surcharge	Employee + Family	75495
M	9/29/1972	55435.190	Advantage Plus- Prem Surcharge	Employee + Family	75002
M	10/4/1967	66638.000	Advantage Plus- Prem Surcharge	Employee + Family	75490
M	2/10/1980	47849.390	Advantage Plus- Prem Surcharge	Employee + Family	75173
M	1/29/1959	62590.220	Advantage Plus- Prem Surcharge	Employee + Family	75002
F	8/14/1965	52902.780	Advantage Plus- Prem Surcharge	Employee + Family	75071
M	10/18/1959	153693.000	Advantage Plus- Prem Surcharge	Employee + Family	75013
M	12/23/1982	53276.300	Advantage Plus- Prem Surcharge	Employee + Family	75459
M	4/9/1981	39769.820	Advantage Plus- Prem Surcharge	Employee + Family	75070
M	12/28/1978	41971.160	Advantage Plus- Prem Surcharge	Employee + Family	75009
M	9/15/1982	52252.600	Advantage Plus- Prem Surcharge	Employee + Family	75071
M	1/23/1957	49678.640	Advantage Plus- Prem Surcharge	Employee + Family	75069
M	12/15/1976	92454.860	Advantage Plus- Prem Surcharge	Employee + Family	75409
M	5/12/1968	38956.000	Advantage Plus- Prem Surcharge	Employee + Family	75070
F	8/4/1985	32643.650	Advantage Plus- Prem Surcharge	Employee + Family	75071
M	3/30/1964	153693.000	Advantage Plus- Prem Surcharge	Employee + Family	75075
M	12/3/1986	35844.290	Advantage Plus- Prem Surcharge	Employee + Family	75025
M	8/28/1984	38956.230	Advantage Plus- Prem Surcharge	Employee + Family	75409

Attachment J - Active Employee Medical Census

F	4/15/1959	133557.990	Advantage Plus- Prem Surcharge	Employee + Family	75040
M	4/27/1955	111045.960	Advantage Plus- Prem Surcharge	Employee + Family	75093
F	3/19/1972	28004.000	Advantage Plus- Prem Surcharge	Employee + Family	75035
M	9/20/1987	34398.900	Advantage Plus- Prem Surcharge	Employee + Family	75082
M	7/9/1986	34290.510	Advantage Plus- Prem Surcharge	Employee + Family	75071
M	4/2/1989	34229.540	Advantage Plus- Prem Surcharge	Employee + Family	75074
F	5/21/1987	32699.220	Advantage Plus- Prem Surcharge	Employee + Family	75409
F	1/30/1970	30180.000	Advantage Plus- Prem Surcharge	Employee + Family	75048
F	2/6/1989	30180.000	Advantage Plus- Prem Surcharge	Employee + Family	75495
M	12/11/1969	35622.260	Advantage Plus- Prem Surcharge	Employee + Family	75082
F	3/27/1982	26084.000	Advantage Plus- Prem Surcharge	Employee + Family	75098
F	5/19/1972	28004.000	Advantage Plus- Prem Surcharge	Employee + Family	75013
F	9/15/1960	26084.000	Advantage Plus- Standard Rate	Employee Only	75442
M	7/26/1970	71572.000	Advantage Plus- Standard Rate	Employee Only	76051
F	12/7/1966	30180.000	Advantage Plus- Standard Rate	Employee Only	75409
M	9/12/1962	32640.000	Advantage Plus- Standard Rate	Employee Only	75034
M	1/12/1990	34005.000	Advantage Plus- Standard Rate	Employee Only	75070
M	4/13/1994	34005.000	Advantage Plus- Standard Rate	Employee Only	75002
F	7/13/1952	26084.000	Advantage Plus- Standard Rate	Employee Only	75409
M	2/11/1983	34005.000	Advantage Plus- Standard Rate	Employee Only	75069
M	9/2/1944	34005.000	Advantage Plus- Standard Rate	Employee Only	76249
F	8/23/1986	50223.000	Advantage Plus- Standard Rate	Employee Only	75069
M	7/20/1964	32640.000	Advantage Plus- Standard Rate	Employee + Spouse	75409
F	1/28/1956	30180.000	Advantage Plus- Standard Rate	Employee + Spouse	75013
M	11/3/1956	104165.390	Advantage Plus- Standard Rate	Employee + Spouse	75023
M	7/21/1990	34005.000	Advantage Plus- Standard Rate	Employee + Spouse	75002
M	1/18/1962	28004.000	Advantage Plus- Standard Rate	Employee + Child(ren)	75071
F	2/2/1987	30180.000	Advantage Plus- Standard Rate	Employee + Child(ren)	75069
F	1/2/1986	32640.000	Advantage Plus- Standard Rate	Employee + Child(ren)	75454
F	9/21/1990	34005.000	Advantage Plus- Standard Rate	Employee + Child(ren)	75054
M	7/31/1973	38446.000	Advantage Plus- Standard Rate	Employee + Family	75070
F	4/22/1982	28350.000	Advantage Plus- Standard Rate	Employee + Family	75025
M	11/17/1959	39192.000	Advantage Plus- Standard Rate	Employee + Family	75069
M	5/3/1955	70000.000	Advantage Plus- Standard Rate	Employee + Family	76002
F	11/2/1963	59870.000	Advantage Plus- Standard Rate	Employee + Family	75454
M	12/31/1975	33273.450	Advantage Plus- Standard Rate	Employee + Family	75068
F	9/8/1986	34005.000	Advantage Plus- Standard Rate	Employee + Family	75409
F	2/14/1982	28004.000	Advantage Plus- Standard Rate	Employee + Family	75023
M	10/23/1958	52229.450	Advantage- Premium Discount	Employee Only	75069
M	7/13/1967	70789.900	Advantage- Premium Discount	Employee Only	75068
F	10/28/1950	63171.440	Advantage- Premium Discount	Employee Only	75082
M	6/6/1967	30496.946	Advantage- Premium Discount	Employee Only	75424
F	7/28/1956	40713.690	Advantage- Premium Discount	Employee Only	75452
F	3/14/1963	27496.700	Advantage- Premium Discount	Employee Only	75407
F	8/11/1948	47849.390	Advantage- Premium Discount	Employee Only	76273

Attachment J - Active Employee Medical Census

F	3/9/1971	56910.270	Advantage- Premium Discount	Employee Only	75071
F	1/8/1954	44317.900	Advantage- Premium Discount	Employee Only	75409
F	4/1/1968	47849.390	Advantage- Premium Discount	Employee Only	75491
M	8/30/1961	56923.170	Advantage- Premium Discount	Employee Only	75771
M	2/9/1953	117170.700	Advantage- Premium Discount	Employee Only	75069
M	7/30/1976	35712.300	Advantage- Premium Discount	Employee Only	75453
F	5/18/1963	68131.460	Advantage- Premium Discount	Employee Only	75407
F	8/22/1967	33359.480	Advantage- Premium Discount	Employee Only	75409
M	10/17/1972	54629.860	Advantage- Premium Discount	Employee Only	76227
M	3/3/1981	52252.600	Advantage- Premium Discount	Employee Only	75407
M	10/22/1973	40580.100	Advantage- Premium Discount	Employee Only	75442
F	7/11/1959	34891.540	Advantage- Premium Discount	Employee Only	75070
F	5/11/1947	42727.000	Advantage- Premium Discount	Employee Only	75490
M	6/26/1971	52196.060	Advantage- Premium Discount	Employee Only	75454
M	10/31/1971	57064.460	Advantage- Premium Discount	Employee Only	75092
F	11/11/1973	38446.000	Advantage- Premium Discount	Employee Only	75035
F	8/1/1952	43402.210	Advantage- Premium Discount	Employee Only	75069
M	10/28/1971	47849.390	Advantage- Premium Discount	Employee Only	75409
F	2/9/1974	33940.570	Advantage- Premium Discount	Employee Only	75069
M	8/1/1970	44364.890	Advantage- Premium Discount	Employee Only	75069
F	4/23/1952	48798.290	Advantage- Premium Discount	Employee Only	75002
F	7/12/1953	38410.770	Advantage- Premium Discount	Employee Only	75407
F	12/21/1968	42088.760	Advantage- Premium Discount	Employee Only	75069
F	9/13/1968	35173.400	Advantage- Premium Discount	Employee Only	75013
F	8/8/1976	48934.990	Advantage- Premium Discount	Employee Only	75216
F	8/21/1963	65510.810	Advantage- Premium Discount	Employee Only	75098
F	2/17/1974	35378.000	Advantage- Premium Discount	Employee Only	75069
M	3/24/1973	61636.690	Advantage- Premium Discount	Employee Only	75002
F	4/8/1978	40546.870	Advantage- Premium Discount	Employee Only	75071
M	11/29/1945	33533.760	Advantage- Premium Discount	Employee Only	75409
F	2/18/1964	37977.500	Advantage- Premium Discount	Employee Only	75495
M	7/14/1980	39995.930	Advantage- Premium Discount	Employee Only	75068
M	4/28/1979	37322.980	Advantage- Premium Discount	Employee Only	75071
F	4/17/1953	28716.730	Advantage- Premium Discount	Employee Only	75069
F	9/9/1980	74414.570	Advantage- Premium Discount	Employee Only	75246
F	11/8/1982	38677.020	Advantage- Premium Discount	Employee Only	75070
M	8/26/1980	74338.620	Advantage- Premium Discount	Employee Only	75071
M	9/8/1981	74877.840	Advantage- Premium Discount	Employee Only	75206
M	5/6/1984	40234.960	Advantage- Premium Discount	Employee Only	75119
M	6/14/1965	46512.880	Advantage- Premium Discount	Employee Only	75002
M	5/17/1969	39088.060	Advantage- Premium Discount	Employee Only	75090
M	8/1/1963	44581.740	Advantage- Premium Discount	Employee Only	75414-2739
M	12/28/1984	38901.690	Advantage- Premium Discount	Employee Only	75070
M	12/16/1983	71723.000	Advantage- Premium Discount	Employee Only	75206
M	7/27/1968	30437.790	Advantage- Premium Discount	Employee Only	75220

Attachment J - Active Employee Medical Census

M	4/20/1965	32640.000	Advantage- Premium Discount	Employee Only	75007
F	5/29/1963	26451.910	Advantage- Premium Discount	Employee Only	75404
F	12/25/1957	54499.520	Advantage- Premium Discount	Employee Only	75035
F	11/25/1983	71723.000	Advantage- Premium Discount	Employee Only	75214
M	1/19/1971	28004.000	Advantage- Premium Discount	Employee Only	75409
M	12/12/1977	38446.000	Advantage- Premium Discount	Employee Only	75020
F	11/13/1984	71723.000	Advantage- Premium Discount	Employee Only	75204
F	3/18/1988	28150.610	Advantage- Premium Discount	Employee Only	75071
F	11/2/1963	30369.140	Advantage- Premium Discount	Employee Only	75002
F	8/31/1983	32959.070	Advantage- Premium Discount	Employee Only	75409
M	7/19/1990	34943.380	Advantage- Premium Discount	Employee Only	75024
F	2/7/1984	32686.540	Advantage- Premium Discount	Employee Only	75070
F	3/12/1990	28004.000	Advantage- Premium Discount	Employee Only	75074
M	8/11/1977	32640.000	Advantage- Premium Discount	Employee Only	75424
F	9/14/1982	38446.000	Advantage- Premium Discount	Employee Only	75070
F	5/7/1987	32640.000	Advantage- Premium Discount	Employee Only	75409
F	8/27/1959	50953.570	Advantage- Premium Discount	Employee Only	75071
F	3/10/1983	66219.000	Advantage- Premium Discount	Employee Only	75077
F	7/28/1953	44647.520	Advantage- Premium Discount	Employee Only	75043
F	9/28/1983	66219.000	Advantage- Premium Discount	Employee Only	75080
F	11/24/1982	54553.380	Advantage- Premium Discount	Employee Only	75409
M	6/20/1978	55197.340	Advantage- Premium Discount	Employee Only	75001
F	10/29/1984	66219.000	Advantage- Premium Discount	Employee Only	75219
F	9/5/1960	41092.660	Advantage- Premium Discount	Employee Only	75070
F	2/28/1987	38980.870	Advantage- Premium Discount	Employee Only	75070
F	6/30/1988	34290.510	Advantage- Premium Discount	Employee Only	75070
F	5/11/1984	66219.000	Advantage- Premium Discount	Employee Only	75205
M	4/19/1967	79717.630	Advantage- Premium Discount	Employee Only	75025
F	9/4/1990	28091.090	Advantage- Premium Discount	Employee Only	75442
F	10/16/1948	30180.000	Advantage- Premium Discount	Employee Only	75070
F	9/1/1988	30183.710	Advantage- Premium Discount	Employee Only	75069
M	12/14/1980	44399.860	Advantage- Premium Discount	Employee Only	75074
M	3/31/1970	41911.000	Advantage- Premium Discount	Employee Only	75002
F	4/28/1988	50223.000	Advantage- Premium Discount	Employee Only	75244
F	7/29/1960	30180.000	Advantage- Premium Discount	Employee Only	75069
M	4/26/1982	34005.000	Advantage- Premium Discount	Employee Only	75056
M	6/28/1975	49742.520	Advantage- Premium Discount	Employee Only	75074
F	10/16/1966	38446.000	Advantage- Premium Discount	Employee Only	75048
F	5/28/1988	53135.210	Advantage- Premium Discount	Employee Only	75401
M	5/20/1988	34005.000	Advantage- Premium Discount	Employee Only	75070
F	1/3/1991	28004.000	Advantage- Premium Discount	Employee Only	75491
M	10/8/1964	52743.310	Advantage- Premium Discount	Employee Only	75173
M	7/31/1978	34926.130	Advantage- Premium Discount	Employee Only	75090
M	3/5/1992	34005.000	Advantage- Premium Discount	Employee Only	75002
M	1/6/1971	34005.000	Advantage- Premium Discount	Employee Only	75020

Attachment J - Active Employee Medical Census

M	10/9/1979	38446.000	Advantage- Premium Discount	Employee Only	76205
F	4/25/1991	55186.000	Advantage- Premium Discount	Employee Only	75070
M	11/10/1986	34005.000	Advantage- Premium Discount	Employee Only	75056
F	4/8/1959	44174.090	Advantage- Premium Discount	Employee + Spouse	75495
F	12/31/1947	59212.820	Advantage- Premium Discount	Employee + Spouse	75495
M	9/20/1960	44314.660	Advantage- Premium Discount	Employee + Spouse	75442
M	5/19/1951	154693.000	Advantage- Premium Discount	Employee + Spouse	75069
F	9/19/1946	48357.980	Advantage- Premium Discount	Employee + Spouse	75002-0634
M	8/5/1962	47227.070	Advantage- Premium Discount	Employee + Spouse	75035
M	1/6/1972	58383.170	Advantage- Premium Discount	Employee + Spouse	75076
F	3/16/1967	47889.040	Advantage- Premium Discount	Employee + Spouse	75069
F	3/12/1969	96370.330	Advantage- Premium Discount	Employee + Spouse	75070
M	4/2/1978	34671.300	Advantage- Premium Discount	Employee + Spouse	75071-2898
M	10/25/1961	65362.900	Advantage- Premium Discount	Employee + Spouse	75020
M	12/5/1963	68230.770	Advantage- Premium Discount	Employee + Spouse	75070
M	1/24/1951	47849.390	Advantage- Premium Discount	Employee + Spouse	75442
M	9/18/1960	38254.830	Advantage- Premium Discount	Employee + Spouse	75442
F	11/25/1955	30180.000	Advantage- Premium Discount	Employee + Spouse	75035
M	12/27/1950	36557.620	Advantage- Premium Discount	Employee + Spouse	75070
M	1/9/1966	32640.000	Advantage- Premium Discount	Employee + Spouse	75442
F	12/6/1985	55196.130	Advantage- Premium Discount	Employee + Spouse	75074
F	11/11/1985	30180.000	Advantage- Premium Discount	Employee + Spouse	75069
F	3/17/1990	32640.000	Advantage- Premium Discount	Employee + Spouse	75407
M	10/13/1986	56608.000	Advantage- Premium Discount	Employee + Spouse	76051
M	2/9/1989	34005.000	Advantage- Premium Discount	Employee + Spouse	75495
M	1/6/1981	57821.610	Advantage- Premium Discount	Employee + Spouse	75189
M	3/3/1955	98585.080	Advantage- Premium Discount	Employee + Spouse	75424
M	5/9/1959	30180.000	Advantage- Premium Discount	Employee + Spouse	75452
M	11/9/1962	32640.000	Advantage- Premium Discount	Employee + Spouse	75088
M	9/30/1987	34005.000	Advantage- Premium Discount	Employee + Spouse	75068
M	4/8/1981	30180.000	Advantage- Premium Discount	Employee + Spouse	75454
M	9/25/1961	41911.000	Advantage- Premium Discount	Employee + Spouse	75491
M	9/17/1963	43279.460	Advantage- Premium Discount	Employee + Child(ren)	75485
M	2/25/1975	48723.620	Advantage- Premium Discount	Employee + Child(ren)	75033
M	2/3/1966	54788.250	Advantage- Premium Discount	Employee + Child(ren)	75407
M	12/12/1960	62412.420	Advantage- Premium Discount	Employee + Child(ren)	75092
M	9/12/1977	45000.110	Advantage- Premium Discount	Employee + Child(ren)	75409
M	7/2/1982	52252.600	Advantage- Premium Discount	Employee + Child(ren)	75092
M	10/21/1966	118792.000	Advantage- Premium Discount	Employee + Child(ren)	75070
M	7/3/1961	68638.200	Advantage- Premium Discount	Employee + Child(ren)	75173
M	6/23/1980	47227.070	Advantage- Premium Discount	Employee + Child(ren)	75092
F	12/30/1976	67089.970	Advantage- Premium Discount	Employee + Child(ren)	75070
M	6/14/1961	60504.490	Advantage- Premium Discount	Employee + Child(ren)	75069
F	3/3/1958	45802.470	Advantage- Premium Discount	Employee + Child(ren)	75013
M	5/2/1975	50544.250	Advantage- Premium Discount	Employee + Child(ren)	75418

Attachment J - Active Employee Medical Census

F	2/1/1961	30183.710	Advantage- Premium Discount	Employee + Child(ren)	75069
M	4/23/1966	52099.500	Advantage- Premium Discount	Employee + Child(ren)	75048
F	6/3/1983	40928.150	Advantage- Premium Discount	Employee + Child(ren)	75078
M	3/7/1970	51983.230	Advantage- Premium Discount	Employee + Child(ren)	75070
M	10/28/1967	46324.500	Advantage- Premium Discount	Employee + Child(ren)	75407
F	5/3/1969	45143.720	Advantage- Premium Discount	Employee + Child(ren)	75458
M	10/5/1977	72070.110	Advantage- Premium Discount	Employee + Child(ren)	75071
M	2/24/1975	45058.490	Advantage- Premium Discount	Employee + Child(ren)	75409
F	2/16/1962	39787.420	Advantage- Premium Discount	Employee + Child(ren)	75025
M	8/11/1968	52884.400	Advantage- Premium Discount	Employee + Child(ren)	75459
F	4/28/1978	40504.740	Advantage- Premium Discount	Employee + Child(ren)	75070
F	8/9/1953	33794.590	Advantage- Premium Discount	Employee + Child(ren)	75069
F	4/7/1982	32696.830	Advantage- Premium Discount	Employee + Child(ren)	75164
F	7/1/1971	50223.000	Advantage- Premium Discount	Employee + Child(ren)	75454
F	12/29/1966	40812.550	Advantage- Premium Discount	Employee + Child(ren)	75070
F	6/15/1982	50630.240	Advantage- Premium Discount	Employee + Child(ren)	75069
F	5/8/1973	32643.650	Advantage- Premium Discount	Employee + Child(ren)	75069
F	1/21/1985	30180.000	Advantage- Premium Discount	Employee + Child(ren)	75071
M	9/19/1963	45003.750	Advantage- Premium Discount	Employee + Child(ren)	75058
M	4/10/1978	38538.360	Advantage- Premium Discount	Employee + Child(ren)	75009
F	3/19/1976	38956.000	Advantage- Premium Discount	Employee + Child(ren)	75071
F	1/12/1966	36136.410	Advantage- Premium Discount	Employee + Child(ren)	75040
F	6/11/1985	30183.710	Advantage- Premium Discount	Employee + Child(ren)	75407
F	6/20/1988	32640.000	Advantage- Premium Discount	Employee + Child(ren)	75069
F	6/1/1974	32746.750	Advantage- Premium Discount	Employee + Child(ren)	75409
M	6/19/1966	85694.340	Advantage- Premium Discount	Employee + Child(ren)	75024
F	6/26/1971	38446.000	Advantage- Premium Discount	Employee + Child(ren)	76114
M	4/2/1979	36296.940	Advantage- Premium Discount	Employee + Child(ren)	75071
F	8/17/1968	30180.000	Advantage- Premium Discount	Employee + Child(ren)	75074
F	12/14/1977	30180.000	Advantage- Premium Discount	Employee + Child(ren)	75490
F	7/6/1977	42921.000	Advantage- Premium Discount	Employee + Child(ren)	75071
F	3/17/1971	32640.000	Advantage- Premium Discount	Employee + Child(ren)	75002
F	4/10/1987	34005.000	Advantage- Premium Discount	Employee + Child(ren)	75495
F	4/13/1982	38446.000	Advantage- Premium Discount	Employee + Child(ren)	75216
M	4/22/1971	49669.920	Advantage- Premium Discount	Employee + Child(ren)	75032
F	8/27/1978	38466.000	Advantage- Premium Discount	Employee + Child(ren)	75070
F	11/2/1983	30180.000	Advantage- Premium Discount	Employee + Child(ren)	75070
F	8/10/1989	26084.000	Advantage- Premium Discount	Employee + Child(ren)	75442
M	8/31/1967	43172.200	Advantage- Premium Discount	Employee + Child(ren)	75447
F	3/26/1991	32640.000	Advantage- Premium Discount	Employee + Child(ren)	75013
F	7/3/1992	26084.000	Advantage- Premium Discount	Employee + Child(ren)	75070
F	4/20/1964	32640.000	Advantage- Premium Discount	Employee + Child(ren)	75002
F	8/18/1980	30180.000	Advantage- Premium Discount	Employee + Child(ren)	75002
M	10/10/1965	104980.520	Advantage- Premium Discount	Employee + Family	75071
M	7/22/1963	42796.480	Advantage- Premium Discount	Employee + Family	75189

Attachment J - Active Employee Medical Census

M	8/5/1966	68638.200	Advantage- Premium Discount	Employee + Family	75407
M	11/11/1970	83804.150	Advantage- Premium Discount	Employee + Family	75423
M	10/17/1976	48723.620	Advantage- Premium Discount	Employee + Family	75002
M	1/22/1963	74651.060	Advantage- Premium Discount	Employee + Family	76209
M	4/2/1976	48834.630	Advantage- Premium Discount	Employee + Family	75002
M	8/24/1970	74131.370	Advantage- Premium Discount	Employee + Family	75070
M	8/13/1960	45815.595	Advantage- Premium Discount	Employee + Family	75092
F	11/7/1982	40984.020	Advantage- Premium Discount	Employee + Family	75409
M	2/8/1963	52293.510	Advantage- Premium Discount	Employee + Family	75009
M	4/24/1979	47526.330	Advantage- Premium Discount	Employee + Family	75021
F	7/13/1954	41316.450	Advantage- Premium Discount	Employee + Family	75009
M	11/11/1981	41911.000	Advantage- Premium Discount	Employee + Family	75013
F	12/7/1959	102446.530	Advantage- Premium Discount	Employee + Family	75002
M	12/25/1972	42849.950	Advantage- Premium Discount	Employee + Family	75090
F	12/25/1973	93730.610	Advantage- Premium Discount	Employee + Family	75022
M	10/13/1962	39367.220	Advantage- Premium Discount	Employee + Family	75424
M	1/1/1972	55257.240	Advantage- Premium Discount	Employee + Family	75009
M	3/25/1974	52196.060	Advantage- Premium Discount	Employee + Family	75438
M	9/5/1955	52188.900	Advantage- Premium Discount	Employee + Family	75071
M	2/12/1971	51845.940	Advantage- Premium Discount	Employee + Family	75459
M	6/24/1953	73208.860	Advantage- Premium Discount	Employee + Family	75070
M	5/8/1973	85957.610	Advantage- Premium Discount	Employee + Family	75071
M	9/9/1985	35261.050	Advantage- Premium Discount	Employee + Family	75409
F	11/25/1963	172951.410	Advantage- Premium Discount	Employee + Family	75132
F	10/30/1966	47722.100	Advantage- Premium Discount	Employee + Family	75495
M	2/5/1964	41911.000	Advantage- Premium Discount	Employee + Family	75071
M	8/21/1960	46868.630	Advantage- Premium Discount	Employee + Family	75407
M	4/12/1963	48475.320	Advantage- Premium Discount	Employee + Family	75070
F	12/16/1971	47947.850	Advantage- Premium Discount	Employee + Family	75458
F	7/21/1966	95583.680	Advantage- Premium Discount	Employee + Family	75078
F	6/11/1963	67419.380	Advantage- Premium Discount	Employee + Family	75424
M	6/12/1973	52043.330	Advantage- Premium Discount	Employee + Family	75043
M	1/2/1958	32640.000	Advantage- Premium Discount	Employee + Family	75409
M	6/28/1981	38684.690	Advantage- Premium Discount	Employee + Family	75407
M	1/20/1973	65308.270	Advantage- Premium Discount	Employee + Family	75002
M	12/7/1976	38153.350	Advantage- Premium Discount	Employee + Family	75407
F	6/24/1973	40332.730	Advantage- Premium Discount	Employee + Family	75090
M	12/22/1958	36465.090	Advantage- Premium Discount	Employee + Family	75442
M	8/13/1981	36809.730	Advantage- Premium Discount	Employee + Family	75013
M	7/20/1984	38987.510	Advantage- Premium Discount	Employee + Family	75071
F	5/29/1974	35382.010	Advantage- Premium Discount	Employee + Family	75070
M	5/9/1989	36795.440	Advantage- Premium Discount	Employee + Family	75409
F	3/7/1980	35382.010	Advantage- Premium Discount	Employee + Family	75135
F	11/20/1980	32870.440	Advantage- Premium Discount	Employee + Family	75454
M	2/6/1975	111046.360	Advantage- Premium Discount	Employee + Family	75070

Attachment J - Active Employee Medical Census

F	12/4/1983	32643.650	Advantage- Premium Discount	Employee + Family	75442
M	4/19/1984	38956.410	Advantage- Premium Discount	Employee + Family	75409
M	1/30/1972	39476.680	Advantage- Premium Discount	Employee + Family	75070
M	5/12/1976	41915.440	Advantage- Premium Discount	Employee + Family	75074
M	9/8/1960	35546.420	Advantage- Premium Discount	Employee + Family	75490
F	3/17/1975	71723.000	Advantage- Premium Discount	Employee + Family	75208
F	8/8/1963	32741.880	Advantage- Premium Discount	Employee + Family	75070
F	6/8/1986	39726.430	Advantage- Premium Discount	Employee + Family	75071
F	5/5/1985	26088.330	Advantage- Premium Discount	Employee + Family	75407
M	12/8/1976	34946.800	Advantage- Premium Discount	Employee + Family	75070
F	2/20/1978	66219.000	Advantage- Premium Discount	Employee + Family	75070
M	9/15/1976	49163.520	Advantage- Premium Discount	Employee + Family	75070
M	4/13/1973	45797.000	Advantage- Premium Discount	Employee + Family	75070
M	10/1/1981	34290.510	Advantage- Premium Discount	Employee + Family	75159
F	7/27/1989	30180.000	Advantage- Premium Discount	Employee + Family	75424
M	10/28/1987	30401.970	Advantage- Premium Discount	Employee + Family	75070
F	9/3/1958	41911.000	Advantage- Premium Discount	Employee + Family	75442
M	3/22/1983	32640.250	Advantage- Premium Discount	Employee + Family	75407
F	11/19/1974	28004.000	Advantage- Premium Discount	Employee + Family	75002
F	4/13/1957	26084.000	Advantage- Premium Discount	Employee + Family	75409
F	4/27/1979	45797.000	Advantage- Premium Discount	Employee + Family	75071
M	11/30/1964	30180.000	Advantage- Premium Discount	Employee + Family	75007
F	8/17/1975	39918.390	Advantage- Premium Discount	Employee + Family	75074
M	1/5/1981	35269.510	Advantage- Premium Discount	Employee + Family	75070
F	11/24/1972	26084.000	Advantage- Premium Discount	Employee + Family	75071
F	3/2/1983	32640.000	Advantage- Premium Discount	Employee + Family	75002
F	3/9/1967	26084.000	Advantage- Premium Discount	Employee + Family	75002
M	9/11/1979	79391.880	Advantage- Premium Surcharge	Employee Only	75206
M	12/19/1967	66638.000	Advantage- Premium Surcharge	Employee Only	75452
M	11/1/1965	47849.390	Advantage- Premium Surcharge	Employee Only	75069
M	12/17/1973	48723.620	Advantage- Premium Surcharge	Employee Only	75091
M	9/10/1976	47849.390	Advantage- Premium Surcharge	Employee Only	75002
M	11/10/1980	47849.390	Advantage- Premium Surcharge	Employee Only	75092
M	11/10/1979	57385.530	Advantage- Premium Surcharge	Employee Only	75071
M	9/4/1985	32640.000	Advantage- Premium Surcharge	Employee Only	75070
M	8/10/1950	30183.710	Advantage- Premium Surcharge	Employee Only	75409
M	9/15/1970	43322.360	Advantage- Premium Surcharge	Employee Only	75058
F	11/30/1953	28004.000	Advantage- Premium Surcharge	Employee Only	75002
M	8/23/1991	30165.580	Advantage- Premium Surcharge	Employee Only	75442
F	6/14/1985	28038.540	Advantage- Premium Surcharge	Employee Only	75044
M	3/13/1988	34476.410	Advantage- Premium Surcharge	Employee Only	75442
M	9/2/1988	36061.170	Advantage- Premium Surcharge	Employee Only	75070
F	6/24/1976	55186.000	Advantage- Premium Surcharge	Employee Only	75409
M	12/19/1990	34005.980	Advantage- Premium Surcharge	Employee Only	75166
F	10/15/1964	41529.190	Advantage- Premium Surcharge	Employee Only	75453

Attachment J - Active Employee Medical Census

F	8/31/1970	32640.000	Advantage- Premium Surcharge	Employee Only	75078
M	11/29/1985	30180.000	Advantage- Premium Surcharge	Employee Only	75409
F	12/13/1958	32640.000	Advantage- Premium Surcharge	Employee Only	75070
M	4/20/1989	34005.000	Advantage- Premium Surcharge	Employee Only	76209
M	12/9/1990	34005.000	Advantage- Premium Surcharge	Employee Only	75166
F	1/2/1987	56608.000	Advantage- Premium Surcharge	Employee Only	75013
F	11/27/1989	38446.000	Advantage- Premium Surcharge	Employee Only	75067
M	10/25/1992	28004.000	Advantage- Premium Surcharge	Employee Only	75078
M	8/25/1980	34926.130	Advantage- Premium Surcharge	Employee Only	75010
F	1/7/1984	34842.890	Advantage- Premium Surcharge	Employee Only	75069
F	3/9/1980	62756.000	Advantage- Premium Surcharge	Employee Only	75070
F	10/6/1960	32640.000	Advantage- Premium Surcharge	Employee Only	75002
M	8/12/1946	47849.390	Advantage- Premium Surcharge	Employee + Spouse	75407
M	9/8/1981	40880.460	Advantage- Premium Surcharge	Employee + Spouse	75071
M	2/13/1966	44668.040	Advantage- Premium Surcharge	Employee + Spouse	75490-2624
M	8/22/1963	47849.390	Advantage- Premium Surcharge	Employee + Spouse	76227
M	2/2/1961	59453.660	Advantage- Premium Surcharge	Employee + Spouse	75454
M	12/27/1954	40625.460	Advantage- Premium Surcharge	Employee + Spouse	75490
F	12/24/1955	45904.830	Advantage- Premium Surcharge	Employee + Spouse	75070
F	3/16/1959	40705.170	Advantage- Premium Surcharge	Employee + Spouse	75495
M	5/13/1966	47849.390	Advantage- Premium Surcharge	Employee + Spouse	75424
M	7/9/1960	99129.040	Advantage- Premium Surcharge	Employee + Spouse	75413
M	12/25/1961	44033.440	Advantage- Premium Surcharge	Employee + Spouse	75442
M	3/18/1956	39192.030	Advantage- Premium Surcharge	Employee + Spouse	75070
M	4/17/1970	30180.000	Advantage- Premium Surcharge	Employee + Spouse	75135
F	10/17/1970	94727.190	Advantage- Premium Surcharge	Employee + Spouse	75071
M	8/23/1984	36296.940	Advantage- Premium Surcharge	Employee + Spouse	75075
M	2/27/1986	53320.000	Advantage- Premium Surcharge	Employee + Spouse	75070
M	4/18/1963	30180.000	Advantage- Premium Surcharge	Employee + Spouse	75164
F	10/1/1981	38446.000	Advantage- Premium Surcharge	Employee + Spouse	75070
M	8/16/1992	34005.000	Advantage- Premium Surcharge	Employee + Spouse	75475
M	8/27/1982	39549.780	Advantage- Premium Surcharge	Employee + Spouse	75088
M	7/30/1962	102201.160	Advantage- Premium Surcharge	Employee + Child(ren)	75409
F	2/22/1973	50542.920	Advantage- Premium Surcharge	Employee + Child(ren)	75009
M	5/13/1972	68638.200	Advantage- Premium Surcharge	Employee + Child(ren)	75033
M	1/3/1961	48076.480	Advantage- Premium Surcharge	Employee + Child(ren)	75424
M	5/25/1971	67416.950	Advantage- Premium Surcharge	Employee + Child(ren)	75409
M	1/14/1972	40517.710	Advantage- Premium Surcharge	Employee + Child(ren)	75002
F	9/17/1967	47768.270	Advantage- Premium Surcharge	Employee + Child(ren)	75093
M	11/13/1966	38446.000	Advantage- Premium Surcharge	Employee + Child(ren)	75068
F	11/30/1987	34290.510	Advantage- Premium Surcharge	Employee + Child(ren)	75070
M	3/23/1989	34344.710	Advantage- Premium Surcharge	Employee + Child(ren)	76227
M	9/23/1974	34290.510	Advantage- Premium Surcharge	Employee + Child(ren)	75002
M	9/9/1985	26084.000	Advantage- Premium Surcharge	Employee + Child(ren)	75442
F	10/13/1966	32640.000	Advantage- Premium Surcharge	Employee + Child(ren)	75459

Attachment J - Active Employee Medical Census

F	11/8/1978	41911.000	Advantage- Premium Surcharge	Employee + Child(ren)	75069
F	3/8/1991	34005.000	Advantage- Premium Surcharge	Employee + Child(ren)	75002
M	12/21/1962	49488.160	Advantage- Premium Surcharge	Employee + Family	75070
M	2/7/1974	54697.590	Advantage- Premium Surcharge	Employee + Family	75071
M	6/19/1973	47851.000	Advantage- Premium Surcharge	Employee + Family	75409
F	2/14/1963	95583.680	Advantage- Premium Surcharge	Employee + Family	75495
M	3/26/1980	58702.770	Advantage- Premium Surcharge	Employee + Family	75424
F	10/28/1972	62194.120	Advantage- Premium Surcharge	Employee + Family	75407
M	6/24/1976	52047.230	Advantage- Premium Surcharge	Employee + Family	75173
M	7/8/1973	55435.190	Advantage- Premium Surcharge	Employee + Family	75070
M	2/9/1971	77234.590	Advantage- Premium Surcharge	Employee + Family	75087
F	8/12/1963	97108.190	Advantage- Premium Surcharge	Employee + Family	75074
F	10/30/1967	114736.010	Advantage- Premium Surcharge	Employee + Family	75070
M	11/2/1972	61685.040	Advantage- Premium Surcharge	Employee + Family	75071
M	10/19/1972	61636.690	Advantage- Premium Surcharge	Employee + Family	75409
M	3/6/1971	47849.390	Advantage- Premium Surcharge	Employee + Family	75495
M	8/26/1977	58766.090	Advantage- Premium Surcharge	Employee + Family	75071
M	6/24/1980	36784.170	Advantage- Premium Surcharge	Employee + Family	75409
M	7/8/1981	54892.440	Advantage- Premium Surcharge	Employee + Family	75409
M	7/9/1964	66190.500	Advantage- Premium Surcharge	Employee + Family	75043
M	3/17/1964	59234.360	Advantage- Premium Surcharge	Employee + Family	75495
M	1/9/1976	58310.290	Advantage- Premium Surcharge	Employee + Family	75069
M	8/30/1980	41739.620	Advantage- Premium Surcharge	Employee + Family	75056
M	2/5/1979	36136.410	Advantage- Premium Surcharge	Employee + Family	75454
F	8/21/1954	87162.840	Advantage- Premium Surcharge	Employee + Family	75234
F	1/23/1979	32640.000	Advantage- Premium Surcharge	Employee + Family	75407
M	7/14/1972	93930.250	Advantage- Premium Surcharge	Employee + Family	75002
M	1/10/1979	32640.000	Advantage- Premium Surcharge	Employee + Family	75098
M	6/6/1957	34683.450	Advantage- Premium Surcharge	Employee + Family	75056
M	9/15/1986	34344.710	Advantage- Premium Surcharge	Employee + Family	75409
F	3/8/1987	30180.000	Advantage- Premium Surcharge	Employee + Family	75173
F	8/4/1970	28004.000	Advantage- Premium Surcharge	Employee + Family	75034
M	1/19/1984	30180.000	Advantage- Premium Surcharge	Employee + Family	75409
M	9/1/1968	128762.410	Advantage- Premium Surcharge	Employee + Family	75023
F	6/4/1975	26084.000	Advantage- Premium Surcharge	Employee + Family	75071
M	2/25/1972	30180.000	Advantage- Premium Surcharge	Employee + Family	75495
M	5/22/1988	34005.000	Advantage- Premium Surcharge	Employee + Family	75154
M	8/23/1985	34926.130	Advantage- Premium Surcharge	Employee + Family	75482
F	4/24/1950	13042.000	Advantage- Standard Rate	Employee Only	75035
F	4/25/1988	34666.000	Advantage- Standard Rate	Employee Only	75409
F	7/19/1989	41911.000	Advantage- Standard Rate	Employee Only	75074
M	1/7/1991	34005.000	Advantage- Standard Rate	Employee Only	75069
F	12/7/1989	38446.000	Advantage- Standard Rate	Employee Only	75093
M	9/18/1979	41911.000	Advantage- Standard Rate	Employee Only	75002
F	4/8/1960	30180.000	Advantage- Standard Rate	Employee Only	75071

Attachment J - Active Employee Medical Census

M	10/11/1987	56608.000	Advantage- Standard Rate	Employee Only	75092
F	3/2/1969	26084.000	Advantage- Standard Rate	Employee Only	75454
F	10/28/1988	45797.000	Advantage- Standard Rate	Employee Only	75075
M	12/9/1955	30180.000	Advantage- Standard Rate	Employee Only	75442
F	1/14/1966	34005.000	Advantage- Standard Rate	Employee Only	75442
F	3/26/1992	30180.000	Advantage- Standard Rate	Employee Only	75459
M	4/23/1976	34005.000	Advantage- Standard Rate	Employee Only	75071
F	2/11/1967	35378.000	Advantage- Standard Rate	Employee Only	75071
F	7/8/1989	45797.000	Advantage- Standard Rate	Employee Only	75204
M	7/17/1986	34005.000	Advantage- Standard Rate	Employee Only	75089
M	10/1/1991	34005.000	Advantage- Standard Rate	Employee Only	75002
M	12/16/1994	34005.000	Advantage- Standard Rate	Employee Only	75068
F	9/17/1978	32640.000	Advantage- Standard Rate	Employee + Spouse	75409
F	11/13/1979	32640.000	Advantage- Standard Rate	Employee + Child(ren)	75070
M	5/7/1983	35705.000	Advantage- Standard Rate	Employee + Child(ren)	75240
F	2/9/1988	34005.000	Advantage- Standard Rate	Employee + Child(ren)	75023
F	5/14/1990	34005.000	Advantage- Standard Rate	Employee + Child(ren)	75402
M	6/20/1969	34005.000	Advantage- Standard Rate	Employee + Child(ren)	75070
F	5/23/1978	26084.000	Advantage- Standard Rate	Employee + Family	75407
M	10/8/1980	47804.000	Advantage- Standard Rate	Employee + Family	75442
F	2/11/1990	34005.000	Advantage- Standard Rate	Employee + Family	75409
M	3/24/1979	53793.000	Advantage- Standard Rate	Employee + Family	75071
M	9/13/1976	30180.000	Advantage- Standard Rate	Employee + Family	75173
M	3/23/1980	30180.000	Advantage- Standard Rate	Employee + Family	75442
M	7/30/1972	30180.000	Advantage- Standard Rate	Employee + Family	75454
F	7/10/1976	47805.000	Advantage- Standard Rate	Employee + Family	75071

Attachment K - 2012 Large Claim Loss with Diagnosis (Larger than \$50,000)

Claimant	Relationship	Employment Status	Medicare Status	Payments	Diagnosis	Status as of 4/30/2014
51	Subscriber	Active	Non-Medicare	\$330,720.39	Chronic Kidney Disease	Covered
	Total			\$330,720.39		
52	Spouse	Active	Non-Medicare	\$257,657.67	Broken Fibula and Tibula	Covered
	Total			\$257,657.67		
53	Subscriber	Active	Non-Medicare	\$3,077.63	Leukemia	Covered
	Retired Subscriber	Retired	Non-Medicare	\$227,841.47		
	Total			\$230,919.10		
3	Subscriber	Active	Non-Medicare	\$184,823.95	Open wound to Knee	Not Covered
	Total			\$184,823.95		
54	Subscriber	Active	Non-Medicare	\$145,291.40	Degeneration of disc	Not Covered
				\$3,374.66		
	Total			\$148,666.06		
55	Subscriber	Active	Non-Medicare	\$144,469.49	Breast Cancer	Covered
	Total			\$144,469.49		
56	Subscriber	Active	Non-Medicare	\$135,806.14	Cardiac Dysrhythmias	Covered
	Total			\$135,806.14		
6	Spouse	Active	Non-Medicare	\$77,150.90	Coronary Atherosclerosis	Covered
			Medicare	\$57,678.78		
	Total			\$134,829.68		
35	Subscriber	Active	Non-Medicare	\$123,175.38	Lung Cancer	Not Covered
			Medicare	\$6,720.59		
	Total			\$129,895.97		
57	Subscriber	Active	Non-Medicare	\$121,731.14	Coronary Atherosclerosis	Not Covered
	Total			\$121,731.14		
58	Subscriber	Active	Non-Medicare	\$120,021.20	Cerebral Embolism	Covered
	Total			\$120,021.20		
59	Subscriber	Active	Non-Medicare	\$118,745.22	Disc Disorder	Covered

Attachment K - 2012 Large Claim Loss with Diagnosis

(Larger than \$50,000)

00	Total			\$118,745.22		
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Claimant	Relationship	Employment Status	Medicare Status	Payments	Diagnosis	Status as of 9/30/2013
60	Subscriber	Active	Non-Medicare	\$112,463.01	Cerebral Occlusion	Covered
			Medicare	\$4,457.97		
	Total			\$116,920.98		
8	Subscriber	Active	Non-Medicare	\$113,682.19	Brain Disorder	Covered
	Total			\$113,682.19		
61	Spouse	Active	Non-Medicare	\$107,161.89	Disc Disorder	Covered
	Total			\$107,161.89		
62	Subscriber	Active	Non-Medicare	\$103,746.55	Cancer	Covered
	Total			\$103,746.55		
63	Spouse	Active - COBRA	Non-Medicare	\$96,437.22	Heart Disease	Covered
	Total			\$96,437.22		
64	Spouse	Active	Non-Medicare	\$96,285.39	Coronary Atherosclerosis	Covered
	Total			\$96,285.39		
65	Spouse	Active	Non-Medicare	\$94,642.99	Senile Cataract	Covered
	Total			\$94,642.99		
45	Retired Subscriber	Retired	Non-Medicare	\$55,381.98	End Stage Renal Disease	Covered
			Medicare	\$38,650.19		
			Total		\$94,032.17	
26	Subscriber	Active	Non-Medicare	\$81,956.40	Breast Cancer	Covered
	Total			\$81,956.40		
66	Child	Active	Non-Medicare	\$80,931.45	Premature Birth	Not Covered
	Total			\$80,931.45		
67	Subscriber	Active	Non-Medicare	\$77,312.42	Coronary Atherosclerosis	Not Covered
			Medicare	\$802.81		
			Total		\$78,115.23	
	Subscriber	Active	Non-Medicare	\$75,142.47	Dysrhythmia	Not Covered

Attachment K - 2012 Large Claim Loss with Diagnosis

(Larger than \$50,000)

68	Subscriber	Active	Medicare	\$1,655.47		
	Total			\$76,797.94		

Claimant	Relationship	Employment Status	Medicare Status	Payments	Diagnosis	Status as of 9/30/2013
69	Spouse	Active	Non-Medicare	\$75,136.65	Dysrhythmia	Covered
			Medicare	\$183.01		
	Total			\$75,319.66		
70	Subscriber	Active	Non-Medicare	\$75,138.46	Disc Disorder	Covered
	Total			\$75,138.46		
71	Subscriber	Active	Non-Medicare	\$74,658.85	Angina Pectoris	Covered
	Total			\$74,658.85		
72	Spouse	Active	Non-Medicare	\$74,483.31	Valve Disorder	Covered
	Total			\$74,483.31		
73	Spouse	Active	Non-Medicare	\$74,269.56	Carotid Artery	Covered
	Total			\$74,269.56		
74	Subscriber	Active	Non-Medicare	\$73,933.86	Prostate Cancer	Covered
	Total			\$73,933.86		
75	Spouse	Active	Non-Medicare	\$72,884.97	Kidney Stones	Covered
	Total			\$72,884.97		
76	Subscriber	Active	Non-Medicare	\$70,121.19	Diverticula of Colon	Covered
	Total			\$70,121.19		
77	Subscriber	Active	Non-Medicare	\$66,440.72	Coronary Atherosclerosis	Not Covered
	Total			\$66,440.72		
78	Spouse	Active	Non-Medicare	\$59,311.90	Sickle Cell Disorder	Covered
			Medicare	\$4,075.07		
			Total		\$63,386.97	
79	Child	Active	Non-Medicare	\$60,177.69	Epilepsy	Covered
	Total			\$60,177.69		
80	Subscriber	Active	Non-Medicare	\$56,075.94	Coronary Atherosclerosis	Covered

Attachment K - 2012 Large Claim Loss with Diagnosis (Larger than \$50,000)

80	Total			\$56,075.94	
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Claimant	Relationship	Employment Status	Medicare Status	Payments	Diagnosis	Status as of 9/30/2013
81	Child	Active	Non-Medicare	\$53,757.99	Poisoning	Covered
	Total			\$53,757.99		

Attachment L - 2013 Large Claim Loss with Diagnosis

(Larger than \$50,000)

Claimant	Relationship	Employment Status	Medicare Status	Payments	Diagnosis	Status as of 4/30/2014
82	Subscriber	Active	Non-Medicare	\$436,699.83	Heart Disorder	Covered
	Total			\$436,699.83		
53	Retired Subscriber	Retired	Non-Medicare	\$353,469.12	Leukemia	Covered
	Total			\$353,469.12		
83	Spouse	Active	Non-Medicare	\$289,239.62	Lupus	Not Covered
	Total			\$289,239.62		
52	Spouse	Active	Non-Medicare	\$251,957.44	Broken Fibula and Tibia	Covered
	Total			\$251,957.44		
84	Subscriber	Active	Non-Medicare	\$183,070.82	Spinal Stenosis	Covered
			Medicare	\$16,752.54		
	Total			\$199,823.36		
85	Child	Active	Non-Medicare	\$185,396.44	Cancer	Covered
	Total			\$185,396.44		
86	Spouse	Active	Non-Medicare	\$150,997.46	Cancer	Covered
	Total			\$150,997.46		
45	Retired Subscriber	Retired	Non-Medicare	\$1,818.77	End Stage Renal Disease	Covered
			Medicare	\$136,449.72		
	Total			\$138,268.49		
87	Spouse	Active	Non-Medicare	\$135,577.97	Coronary Syndrome	Covered
	Total			\$135,577.97		
88	Child	Active	Non-Medicare	\$5,553.21	Premature Newborn	Covered
	Newborn	Active	Non-Medicare	\$126,904.43		
	Total			\$132,457.64		
89	Subscriber	Active	Non-Medicare	\$122,840.09	Premature Labor	Covered
	Total			\$122,840.09		

Attachment L - 2013 Large Claim Loss with Diagnosis (Larger than \$50,000)

90	Retired Subscriber	Retired	Non-Medicare	\$117,385.87	Osteoarthritis	Covered
	Total			\$117,385.87		
91	Subscriber	Active	Non-Medicare	\$116,958.82	Cancer of the tongue	Covered
	Total			\$116,958.82		
92	Subscriber	Active	Non-Medicare	\$112,731.86	Paroxysmal Ventricular Tachycardia	Not Covered
			Medicare	\$844.78		
	Total			\$113,576.64		
93	Subscriber	Active	Non-Medicare	\$97,140.59	Disc Disorder	Covered
	Total			\$97,140.59		
94	Subscriber	Active	Non-Medicare	\$94,833.99	Pleurisy	Not Covered
	Total			\$94,833.99		
95	Subscriber	Active	Non-Medicare	\$93,842.19	Osteoarthritis	Covered
			Medicare	\$635.54		
	Total			\$94,477.73		
96	Spouse	Active	Non-Medicare	\$87,460.88	Benign Neoplasm of Lower Jaw Bone	Not Covered
	Total			\$87,460.88		
97	Spouse	Active	Non-Medicare	\$77,123.16	Kidney Stone	Covered
			Medicare	\$7,725.57		
	Total			\$84,848.73		
34	Retired Subscriber	Retired	Non-Medicare	\$83,509.64	Breast Cancer	Covered
	Total			\$83,509.64		
78	Spouse	Active	Non-Medicare	\$74,209.08	Sickle Cell Disorder	Covered
			Medicare	\$9,020.96		
	Total			\$83,230.04		
3	Subscriber	Active	Non-Medicare	\$81,599.28	Wound to Leg	Not Covered
			Medicare	\$631.89		

Attachment L - 2013 Large Claim Loss with Diagnosis

(Larger than \$50,000)

	Total			\$82,231.17		
69	Spouse	Active	Non-Medicare	\$81,109.36	Cardiac Dysrhythmias	Covered
			Medicare	\$25.24		
	Total			\$81,134.60		
98	Retired Subscriber	Retired	Non-Medicare	\$80,555.94	Lung Cancer	Not Covered
	Total			\$80,555.94		
26	Subscriber	Active	Non-Medicare	\$79,226.06	Breast Cancer	Covered
	Total			\$79,226.06		
99	Child	Active	Non-Medicare	\$76,031.25	Cardiac Dysrhythmias	Covered
	Total			\$76,031.25		
100	Spouse	Active	Non-Medicare	\$69,336.25	Lung Cancer	Not Covered
			Medicare	\$5,721.40		
	Total			\$75,057.65		
101	Subscriber	Active	Non-Medicare	\$72,857.32	Coronary Atherosclerosis	Covered
			Medicare	\$79.35		
	Total			\$72,936.67		
102	Spouse	Active	Non-Medicare	\$72,634.50	Pregnancy Complications	Covered
	Total			\$72,634.50		
103	Spouse	Active	Non-Medicare	\$72,417.95	Cerebral Artery Occlusion	Covered
	Total			\$72,417.95		
9	Subscriber	Active	Non-Medicare	\$70,525.21	Disc Disorder	Covered
	Total			\$70,525.21		
104	Child	Active	Non-Medicare	\$67,519.92	Regional Enteritis	Covered
	Total			\$67,519.52		
105	Subscriber	Active	Non-Medicare	\$66,505.91	Cancer	Covered
	Total			\$66,505.91		

Attachment L - 2013 Large Claim Loss with Diagnosis

(Larger than \$50,000)

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106	Spouse	Active	Non-Medicare	\$64,117.56	Embolism	Covered
	Total			\$64,117.56		
107	Subscriber	Active	Non-Medicare	\$60,922.12	Intervertebral Disc Disorder with Myelopathy	Not Covered
	Total			\$60,922.12		
108	Subscriber	Active	Non-Medicare	\$60,214.39	Osteoarthritis	Covered
	Total			\$60,214.39		
51	Subscriber	Active	Non-Medicare	\$58,050.74	Cardiomyopathies	Covered
	Total			\$58,050.74		
109	Subscriber	Active	Non-Medicare	\$57,669.55	Non-infectious Gastroenteritis and Colitis; Palpitations	Covered
	Total			\$57,669.55		
110	Subscriber	Active	Non-Medicare	\$57,413.54	Cervical Spondylosis Without Myelopathy	Covered
	Total			\$57,413.54		
111	Subscriber	Active	Non-Medicare	\$57,217.46	Osteoarthritis	Covered
	Total			\$57,217.46		
6	Spouse	Active	Non-Medicare	\$33,736.28	Deviated Nasal Septum	Covered
			Medicare	\$23,216.52		
	Total			\$56,952.80		
112	Spouse	Active	Non-Medicare	\$56,203.11	Heart Failure	Covered
			Medicare	\$187.11		
	Total			\$56,390.22		
13	Student/Child	Active	Non-Medicare	\$56,286.50	Cleft Palate with Cleft Lip	Covered
	Total			\$56,286.50		
113	Spouse	Active	Non-Medicare	\$56,245.09	Closed Fracture of Upper End of Radius and Ulna	Covered
	Total			\$56,245.09		

Attachment L - 2013 Large Claim Loss with Diagnosis

(Larger than \$50,000)

114	Subscriber	Active	Non-Medicare	\$53,395.39	Osteoporosis	Not Covered
	Total			\$53,395.39		

115	Subscriber	Active	Non-Medicare	\$51,405.83	Osteoarthritis	Covered
	Total			\$51,405.83		
116	Subscriber	Active	Non-Medicare	\$50,958.33	Coronary Atherosclerosis	Not Covered
	Total			\$50,958.33		

Attachment M - 2014 Large Claim Loss with Diagnosis
(Larger than \$50,000)

Claimant	Relationship	Employment Status	Medicare Status	Payments	Diagnosis	Status as of 4/30/2014
117	Subscriber	Active	Non-Medicare	(\$9,208.68)	Coronary Atherosclerosis	Covered
				\$116,849.82		
	Total			\$107,641.14		
118	Child	Active	Non-Medicare	\$88,916.88	Head wound resulting in a hemorrhage	Covered
	Total			\$88,916.88		
119	Subscriber	Active	Non-Medicare	\$79,231.76	Spinal Degeneration / congenital anomalies of spine	Covered
	Total			\$79,231.76		
63	Spouse	Active	Non-Medicare	\$76,743.90	Cervical spondylosis with myelopathy	Covered
	Total			\$76,743.90		
120	Subscriber	Active	Non-Medicare	\$74,225.29	Osteoarthritis	Covered
	Total			\$74,225.29		
121	Subscriber	Active	Non-Medicare	\$71,860.20	Coronary Atherosclerosis	Covered
	Total			\$71,860.20		
122	Spouse	Active	Non-Medicare	\$69,141.90	Fitting and adjustment of automatic implantable cardiac c	Covered
	Total			\$69,141.90		
123	Subscriber	Active	Non-Medicare	\$66,694.68	Thoracic neuritis / congenital anomalies of spine	Covered
	Total			\$66,694.68		
62	Subscriber	Active	Non-Medicare	\$65,466.65	Ovary cancer	Covered
	Total			\$65,466.65		
124	Subscriber	Active	Non-Medicare	\$61,552.41	Prostate cancer	Covered
	Total			\$61,552.41		
71	Subscriber	Active	Non-Medicare	\$59,185.30	Cancer of liver and colon; enlargement of lymph nodes	Covered
	Total			\$59,185.30		
99	Child	Active	Non-Medicare	\$58,122.60	Cardiac Dsrhythmias	Covered
	Total			\$58,122.60		
125	Spouse	Active	Non-Medicare	\$55,930.58	Wound to the leg	Covered
	Total			\$55,930.58		

Attachment M - 2014 Large Claim Loss with Diagnosis
(Larger than \$50,000)

**SIGNATURE FORM
COLLIN COUNTY, TEXAS**

DELIVERY WILL BE F.O.B. INSIDE DELIVERY AT COLLIN COUNTY DESIGNATED LOCATIONS AND ALL TRANSPORTATION CHARGES PAID BY THE SUPPLIER TO DESTINATION.

DELIVERY TO BE SPECIFIED IN CALENDAR DAYS FROM DATE OF ORDER.

WE **DO NOT** TAKE EXCEPTION TO THE BID SPECIFICATIONS.

WE **TAKE** EXCEPTION TO THE BID SPECIFICATIONS (EXPLAIN):

5

6

COMPANY INFORMATION/PROFILE/REFERENCES

Preferential Requirement: The County of Collin, as a governmental agency of the State of Texas, may not award a contract to a nonresident bidder unless the nonresident's bid is lower than the lowest bid submitted by a responsible Texas resident bidder by the same amount that a Texas resident bidder would be required to underbid a nonresident bidder to obtain a comparable contract in the state in which the nonresident's principal place of business is located (Government Code, Title 10, V.T.C.A., Chapter 2252, Subchapter A). Bidder shall make answer to the following questions by selecting the appropriate radio button or inserting information in the box provided:

Is your principal place of business in the State of Texas? Yes No

If the answer to question is "yes", no further information is necessary; if "no", please indicate:

in which state is your principal place of business is located:

if that state favors resident bidders (bidders in your state) by some Yes No
dollar increment or percentage:

if "yes", what is that dollar increment or percentage?

Company Profile: IS YOUR FIRM?

Sole Proprietorship Yes No

General Partnership Yes No

Limited Partnership Yes No

Corporation Yes No

Other Yes No

List Legal Names in Company:

List at least three (3) companies or governmental agencies where these same/like products/services, as stated herein, have been provided. Include company name, address, contact name and telephone number.



AS PERMITTED UNDER TITLE 8, CHAPTER 271, SUBCHAPTER F, SECTION 271.101 AND 271.102 V.T.C.A. AND TITLE 7, CHAPTER 791, SUBCHAPTER C, SECTION 791.025, V.T.C.A., OTHER LOCAL GOVERNMENTAL ENTITIES MAY WISH TO ALSO PARTICIPATE UNDER THE SAME TERMS AND CONDITIONS CONTAINED IN THIS CONTRACT. EACH ENTITY WISHING TO PARTICIPATE MUST ENTER INTO AN INTERLOCAL AGREEMENT WITH COLLIN COUNTY AND HAVE PRIOR AUTHORIZATION FROM VENDOR. IF SUCH PARTICIPATION IS AUTHORIZED, ALL PURCHASE ORDERS WILL BE ISSUED DIRECTLY FROM AND SHIPPED DIRECTLY TO THE LOCAL GOVERNMENTAL ENTITY REQUIRING SUPPLIES/SERVICES. COLLIN COUNTY SHALL NOT BE HELD RESPONSIBLE FOR ANY ORDERS PLACED, DELIVERIES MADE OR PAYMENT FOR SUPPLIES/SERVICES ORDERED BY THESE ENTITIES. EACH ENTITY RESERVES THE RIGHT TO DETERMINE THEIR PARTICIPATION IN THIS CONTRACT. WOULD BIDDER BE WILLING TO ALLOW OTHER LOCAL GOVERNMENTAL ENTITIES TO PARTICIPATE IN THIS CONTRACT, IF AWARDED, UNDER THE SAME TERMS AND CONDITIONS? Yes No

By signing and submitting this Bid/Proposal, Bidder/Offeror acknowledges, understands the specifications, any and all addenda, and agrees to the bid/proposal terms and conditions and can provide the minimum requirements stated herein. Bidder/Offeror acknowledges they have read the document in its entirety, visited the site, performed investigations and verifications as deemed necessary, is familiar with local conditions under which work is to be performed and will be responsible for any and all errors in Bid/Proposal submittal resulting from Bidder/Offeror's failure to do so. Bidder/Offeror acknowledges the prices submitted in this Bid/Proposal have been carefully reviewed and are submitted as correct and final. If Bid/Proposal is accepted, vendor further certifies and agrees to furnish any and all products/services upon which prices are extended at the price submitted, and upon conditions in the specifications of the Invitation for Bid/Request for Proposal.

THE UNDERSIGNED HEREBY CERTIFIES THE FOREGOING BID/PROPOSAL SUBMITTED BY THE COMPANY LISTED BELOW HEREINAFTER CALLED "BIDDER/OFFEROR" IS THE DULY AUTHORIZED AGENT OF SAID COMPANY AND THE PERSON SIGNING SAID BID/PROPOSAL HAS BEEN DULY AUTHORIZED TO EXECUTE SAME. BIDDER/OFFEROR AFFIRMS THAT THEY ARE DULY AUTHORIZED TO EXECUTE THIS CONTRACT; THIS COMPANY; CORPORATION, FIRM, PARTNERSHIP OR INDIVIDUAL HAS NOT PREPARED THIS BID/PROPOSAL IN COLLUSION WITH ANY OTHER BIDDER/OFFEROR OR OTHER PERSON OR PERSONS ENGAGED IN THE SAME LINE OF BUSINESS; AND THAT THE CONTENTS OF THIS BID/PROPOSAL AS TO PRICES, TERMS AND CONDITIONS OF SAID BID/PROPOSAL HAVE NOT BEEN COMMUNICATED BY THE UNDERSIGNED NOR BY ANY EMPLOYEE OR AGENT TO ANY OTHER PERSON ENGAGED IN THIS TYPE OF BUSINESS PRIOR TO THE OFFICIAL OPENING OF THIS BID/PROPOSAL.

Company Name	<input type="text"/>
Street Address of Principal Place of Business	<input type="text"/>
City, State, Zip	<input type="text"/>

Phone of Principal Place of Business	<input type="text"/>
Fax of Principal Place of Business	<input type="text"/>
E-mail Address of Representative	<input type="text"/>
Federal Identification Number	<input type="text"/>
Date	<input type="text"/>
Acknowledgement of Addenda	#1 <input type="checkbox"/> #2 <input type="checkbox"/> #3 <input type="checkbox"/> #4 <input type="checkbox"/> #5 <input type="checkbox"/> #6 <input type="checkbox"/>
Authorized Representative Name	<input type="text"/>
Authorized Representative Title	<input type="text"/>
Signature (Required for paper bid submission)	<input type="text"/>

AFFIDAVIT OF COMPLIANCE

^ ^ ^ ^ ^ ^ ^ ^ ^ ^ I, the undersigned, declare and affirm that my company is in compliance with the Immigration and Reform Act of 1986 and all employees are legally eligible to work in the United States of America.

^
^ ^ ^ ^ ^ ^ ^ ^ ^ ^ I further understand and acknowledge that any non-compliance with the Immigration and Reform Act of 1986 at any time during the term of this contract will render the contract voidable.

Name of Company

Title of Officer

Name of Officer

Date:

In order to better serve our bidders, the Collin County Purchasing Department is conducting the following survey. We appreciate your time and effort expended to submit your bid. Please take a moment to complete the below. Should you have any questions or require more information please call (972) 548-4165.

HOW DID YOU RECEIVE NOTICE OF THIS REQUEST FOR BID OR PROPOSALS?

McKinney Courier-Gazette? Yes No

Plan Room? Yes No

Collin County Web-Site? Yes No

Facsimile or email from BidSync? Yes No

Other

HOW DID YOU RECEIVE THE BID DOCUMENTS?

Downloaded from Home Computer? Yes No

Downloaded from Company Computer? Yes No

Requested a Copy from Collin County? Yes No

Other

Thank You,

Collin County Purchasing Department

Question and Answers for Bid #2014-301 - INSURANCE, MEDICAL STOP LOSS

OVERALL BID QUESTIONS

There are no questions associated with this bid. If you would like to submit a question, please click on the "Create New Question" button below.