COLLIN COUNTY

Insurance, Stop Loss Medical and Pharmacy
RFP 2017-365

Geri Osinaike, Senior Buyer
Jack Hatchell Administration Building
2300 Bloomdale Road, Ste. 3160
McKinney, TX 75071
(P) 972-548-4107 (F) 972-548-4694
gosinaike@co.collin.tx.us

Collin County exclusively uses IonWave Technologies, Inc. (Collin County eBid) for the notification and dissemination of all solicitations. The receipt of solicitations through any other means may result in your receipt of incomplete specifications and/or addendums which could ultimately render your bid/proposal non-compliant. Collin County accepts no responsibility for the receipt and/or notification of solicitations through any other means.

Collin County, Texas

Bid Information

Bid Owner	Geri Osinaike, CPPO, CPPB Senior Buyer
Email	gosinaike@co.collin.tx.us
Phone	(972) 548-4107
Fax	(972) 548-4694
Bid Number	2017-365
Title	Insurance, Stop Loss for Medical and Pharmacy
Bid Type	RFP
Issue Date	11/07/2017
Close Date	11/30/2017 02:00:00 PM (CT)

Contact Information

Address	2300 Bloomdale Rd. Ste. 3160 McKinney, TX 75071
Contact	Geri Osinaike, CPPO, CPPB Senior Buyer
Department	Purchasing
Building	Admin. Building
Floor/Room	Ste.3160
Telephone	(972) 548-4107
Fax	(972) 548-4694
Email	gosinaike@co.collin.tx.us

Ship to Information

Address	
Contact	
Department	
Building	
Floor/Room	
Telephone	
Fax	
Email	

Supplier Information

Company Name _____
Contact Name _____
Address _____
_____
_____
Telephone _____
Fax _____
Email _____

Supplier Notes

_____
_____
_____
_____
_____
_____
_____
_____

The undersigned hereby certifies the foregoing proposal submitted by the company listed below hereinafter called “offeror” is the duly authorized agent of said company and the person signing said proposal has been duly authorized to execute same. Offeror affirms that they are duly authorized to execute this contract; this company; corporation, firm, partnership or individual has not prepared this proposal in collusion with any other offeror or other person or persons engaged in the same line of business; and that the contents of this proposal as to prices, terms and conditions of said 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 proposal.

Signature _____ Date / /

Bid Notes

Bid Activities

Date	Name	Description
11/16/2017 02:00 PM (CT)	Deadline to Submit Questions	Deadline to Submit Questions Thursday November 16, 2017 at 2:00 pm.
11/16/2017 02:00 PM (CT)	Intent to Submit Proposal	Do you intend to submit a proposal?

Bid Messages

Bid Attachments

The following attachments are associated with this opportunity and will need to be retrieved separately

#	Filename	Description
Header	Cover Sheet 2017-365.pdf	Cover Sheet 2017-365
Header	Legal Notice - Insurance, Long Term Care RFP 2017-365.pdf	Legal Notice
Header	Bid Doc Stop Loss.pdf	Bid Package (Complete if submitting manual bid)
Header	General_Instructions_Proposals.docx	General_Instructions_Proposals
Header	Terms_of_Contract_Proposals.docx	Terms_of_Contract_Proposals
Header	Insurance updated 1-26-2015.doc	Minimum Insurance Requirements
Header	Specification 10-2017.docx	Specification
Header	Attachment A_Stop Loss Questionnaire.docx	Attachment A - Stop Loss Questionnaire
Header	Attachment B_ Stop Loss RFP Questionnaire.xlsx	Attachment B - Stop Loss RFP Questionnaire
Header	Attachment C_Pricing Information.docx	Attachment C - Pricing Information
Header	Exhibit 1 - 2018 Dual Plan Summary.pdf	Exhibit 1 - 2018 Dual Plan Summary
Header	Exhibit 2 - 2017 Dual Plan Summary.pdf	Exhibit 2 - 2017 Dual Plan Summary
Header	Exhibit 3 - 2016 Dual Plan Summary.pdf	Exhibit 3 - 2016 Dual Plan Summary
Header	Exhibit 4 - Policy Data - Advantage Plan.docx	Exhibit 4 - Policy Data - Advantage Plan
Header	Exhibit 5 - Policy Data - Advantage Plus Plan.docx	Exhibit 5 - Policy Data - Advantage Plus Plan
Header	Exhibit 6 - Participant Medical Census (08-31-2017).xlsx	Exhibit 6 - Participant Medical Census (08-31-2017)
Header	Exhibit 7 - 2017 Large Claim Loss with Diagnosis 01-01-2017 to 08-31-2017.xlsx	Exhibit 7 - 2017 Large Claim Loss with Diagnosis 01-01-2017 to 08-31-2017
Header	Exhibit 8 - 2016 Large Claim Loss with Diagnosis.xlsx	Exhibit 8 - 2016 Large Claim Loss with Diagnosis
Header	Exhibit 9 - 2015 Large Claim Loss with Diagnosis.xlsx	Exhibit 9 - 2015 Large Claim Loss with Diagnosis
Header	Exhibit 10 - 2014 Large Claim Loss with Diagnosis.xlsx	Exhibit 10 - 2014 Large Claim Loss with Diagnosis
Header	HB89 Verification.docx	HB89/Chapter 2270 Verification
Header	CIQ_113015.pdf	Conflict of Interest Questionnaire
Header	HB23 CIQ 2017-365.pdf	Information Regarding Conflict of Interest Questionnaire
Header	W9_2014.pdf	W-9

Bid Attachments Requested

The following attachments are requested with this opportunity

#	Required	Specified Attachment
1	YES	Proposal/Response to RFP
2	YES	Attachment A:
3	YES	Attachment B
4	YES	Attachment C

Bid Attributes

Please review the following and respond where necessary

#	Name	Note	Response
1	Delivery	Delivery will be F.O.B. inside delivery at Collin County designated locations and all transportation charges are to be paid by the supplier to destination. Please state delivery in calendar days from date of order.	_____ (Required)
2	Exceptions	Do you take exceptions to the specifications. If so, by separate attachment, please state your exceptions. Valid Responses: [Please Select], Yes, No	_____ (Required)
3	Insurance	I understand that the insurance requirements of this solicitation are required and a certificate of insurance shall be submitted to the Purchasing department if I am awarded all or a portion of the resulting contract. Please initial.	_____ (Required)
4	Reference No. 1	List a company or governmental agency where these same/like products /services, as stated herein, have been provided. Include the following: Company/Entity, Contact, Address, City/State/Zip, Phone, and E-Mail.	_____ (Required)
5	Reference No. 2	List a company or governmental agency where these same/like products /services, as stated herein, have been provided. Include the following: Company/Entity, Contact, Address, City/State/Zip, Phone, and E-Mail.	_____ (Required)
6	Reference No. 3	List a company or governmental agency where these same/like products /services, as stated herein, have been provided. Include the following: Company/Entity, Contact, Address, City/State/Zip, Phone, and E-Mail.	_____ (Required)
7	Preferential Treatment	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).	_____ (Required)

1. Is your principal place of business in the State of Texas?

2. If your principal place of business is not in Texas, in which State is your principal place of business?

3. If your principal place of business is not in Texas, does your state favor resident bidders (bidders in your state) by some dollar increment or percentage?

4. If your state favors resident bidders, state by what dollar amount or percentage.

8	Debarment Certification	I certify that neither my company nor an owner or principal of my company has been debarred, suspended or otherwise made ineligible for participation in Federal Assistance programs under Executive Order 12549, "Debarment and Suspension," as described in the Federal Register and Rules and Regulations. Please initial.	_____ (Required)
9	Immigration and Reform Act	I 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 by Collin County. Please initial.	_____ (Required)
10	Disclosure of Certain Relationships	Chapter 176 of the Texas Local Government Code requires that any vendor considering doing business with a local government entity disclose the vendor's affiliation or business relationship that might cause a conflict of interest with a local government entity. Subchapter 6 of the code requires a vendor to file a conflict of interest questionnaire (CIQ) if a conflict exists. By law this questionnaire must be filed with the records administrator of Collin County no later than the 7th business day after the date the vendor becomes aware of an event that requires the statement to be filed. A vendor commits an offense if the vendor knowingly violates the code. An offense under this section is a misdemeanor. By submitting a response to this request, the vendor represents that it is in compliance with the requirements of Chapter 176 of the Texas Local Government Code. Please send completed forms to the Collin County County Clerk's Office located at 2300 Bloomdale Rd., Suite 2104, McKinney, TX 75071. Please initial.	_____ (Required)
11	Anti-Collusion Statement	Bidder certifies that its Bid/Proposal is made without prior understanding, agreement, or connection with any corporation, firm, or person submitting a Bid/Proposal for the same materials, services, supplies, or equipment and is in all respects fair and without collusion or fraud. No premiums, rebates or gratuities permitted; either with, prior to, or after any delivery of material or provision of services. Any such violation may result in Agreement cancellation, return of materials or discontinuation of	_____ (Required)

services and the possible removal from bidders list.

Please initial.

12	Disclosure of Interested Parties	Section 2252.908 of the Texas Government Code requires a business entity entering into certain contracts with a governmental entity to file with the governmental entity a disclosure of interested parties at the time the business entity submits the signed contract to the governmental entity. Section 2252.908 requires the disclosure form (Form 1295) to be signed by the authorized agent of the contracting business entity, acknowledging that the disclosure is made under oath and under penalty of perjury. Section 2252.908 applies only to a contract that requires an action or vote by the governing body of the governmental entity before the contract may be signed or has a value of at least $1 million. Section 2252.908 provides definitions of certain terms occurring in the section. Section 2252.908 applies only to a contract entered into on or after January 1, 2016. Please initial.	_____ (Required)
13	Notification Survey	In order to better serve our offerors, the Collin County Purchasing Department is conducting the following survey. We appreciate your time and effort expended to submit your bid. Should you have any questions or require more information please call (972) 548-4165. How did you receive notice of this request? Valid Responses: [Please Select], Plano Star Courier, Plan Room, Collin County eBid Notification, Collin County Website, Other	_____ (Required)
14	Proposer Acknowledgement	Proposer acknowledges, understands the specifications, any and all addenda, and agrees to the proposal terms and conditions and can provide the minimum requirements stated herein. 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 Proposal submittal resulting from Proposer's failure to do so. Proposer acknowledges the prices submitted in this Proposal have been carefully reviewed and are submitted as correct and final. If 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 Request for Proposal. Please initial.	_____ (Required)

Line Items

#	Qty	UOM	Description	Response
1			Complete Attachment C Price Sheet	$_____ (Optional) No Price

Supplier Notes: _____

LEGAL NOTICE

By order of the Commissioners' Court of Collin County, Texas, sealed proposals will be received by the Purchasing Agent, 2300 Bloomdale Road, Suite 3160, McKinney, TX 75071, until **2:00 P.M., Thursday, November 30, 2017** for Request for Proposal **Insurance, Stop Loss Medical and Pharmacy RFP No. 2017-365,** Court Order. Proposers shall use lump sum pricing or unit pricing as needed for the services. Funds for payment have been provided through the Collin County budget approved by the Commissioner's Court for this fiscal year only. Proposers may obtain detailed specifications and other documents at Office of the Purchasing Agent: Collin County Administration Building, 2300 Bloomdale, Suite 3160, McKinney, TX 75071, 972-548-4165, or by going to: http://collincountytx.ionwave.net. Sealed proposals will be opened on **Thursday, November 30, 2017 at 2:00 P.M**. by the Purchasing Agent, 2300 Bloomdale, Suite 3160, and McKinney, TX 75071. The Commissioners' Court reserves the right to reject any and all proposals.

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ATTENTION: CLASSIFIEDS
BILL TO: ACCOUNT NO 06100315-00
COMMISIONERS' COURT

NOTICE TO PUBLISHERS: Please publish in your issue on **Thursday, November 9, 2017** and **Thursday, November 16, 2017.** A copy of this notice and the publishers' affidavit must accompany the invoice when presented for payment.

NEWSPAPER: Plano Star Courier
DATE: November 7, 2017

FAX: 972-529-1684

2.0 **TERMS OF CONTRACT**

2.1 A 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.

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 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 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 Expenses for Enforcement. In the event either Party hereto is required to employ an attorney to enforce the provisions of this Agreement or is required to commence legal proceedings to enforce the provisions hereof, the prevailing Party shall be entitled to recover from the other, reasonable attorney's fees and court costs incurred in connection with such enforcement, including collection.

2.11 If a contract, resulting from a Collin County RFP/CSP is for the execution of a public work, the following shall apply:

2.11.1 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).

2.11.2 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).

2.12 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.

2.13 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.

2.14 Collin County Purchasing Department shall serve as Contract Administrator or shall supervise agents designated by Collin County.

2.15 All delivery and freight charges (FOB Inside delivery at Collin County designated locations) are to be included as part of the proposal price. All components required to render the item complete, installed and operational shall be included in the total proposal price. Collin County will pay no additional freight/delivery/installation/setup fees.

2.16 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.

2.17 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.

2.18 Invoices shall be mailed directly to the Collin County Auditor's Office, 2300 Bloomdale Road, Suite 3100, McKinney, Texas 75071. All invoices shall show:

2.18.1 Collin County Purchase Order Number;

2.18.2 Vendor's/Contractor's/Provider's Name, Address and Tax Identification Number;

2.18.3 Detailed breakdown of all charges for the product(s) and/or service(s) including applicable time frames.

2.19 Payment will be made in accordance with V.T.C.A., Government Code, Title 10, Subtitle F, Chapter 2251.

2.20 All warranties shall be stated as required in the Uniform Commercial Code.

2.21 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.

2.22 The Vendor/Contractor/Provider agree to protect Collin County from any claims involving infringements of patents and/or copyrights.

2.23 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.

2.24 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.

2.25 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.

2.26 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.

2.27 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.

2.28 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.

2.29 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.

2.30 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.

2.31 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.

2.32 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 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 proposal submission and time of award, the Offeror will notify the Collin County Purchasing Agent. Failure to do so may result in terminating this contract for default.

2.33 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.

2.34 Delays and Extensions of Time when applicable:

2.34.1 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/Enginner may determine.

2.34.2 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.

2.35 Disclosure of Certain Relationships: Chapter 176 of the Texas Local Government Code requires that any vendor considering doing business with a local government entity disclose the vendor's affiliation or business relationship that might cause a conflict of interest with a local government entity. Subchapter 6 of the code requires a vendor to file a conflict of interest questionnaire (CIQ) if a conflict exists. By law this questionnaire must be filed with the records administrator of Collin County no later than the 7th business day after the date the vendor becomes aware of an event that requires the statement to be filed. A vendor commits an offense if the vendor knowingly violates the code. An offense under this section is a misdemeanor. By submitting a response to this request, the vendor represents that it is in compliance with the requirements of Chapter 176 of the Texas Local Government Code. Please send

completed forms to the Collin County County Clerk's Office located at 2300 Bloomdale Rd., Suite 2104, McKinney, TX 75071.

2.36 Disclosure of Interested Parties: Section 2252.908 of the Texas Government Code requires a business entity entering into certain contracts with a governmental entity to file with the governmental entity a disclosure of interested parties at the time the business entity submits the signed contract to the governmental entity. Section 2252.908 requires the disclosure form (Form 1295) to be signed by the authorized agent of the contracting business entity, acknowledging that the disclosure is made under oath and under penalty of perjury. Section 2252.908 applies only to a contract that requires an action or vote by the governing body of the governmental entity before the contract may be signed or has a value of at least $1 million. Section 2252.908 provides definitions of certain terms occurring in the section. Section 2252.908 applies only to a contract entered into on or after January 1, 2016.

2.37 Vendors/Contractors/Providers must be in compliance with the provisions of Section 2270.001 of the Texas Government Code which states a governmental entity may not enter into a contract with a company for goods or services unless the contract contains a written verification from the company that it: (1) does not boycott Israel; and, (2) will not boycott Israel during the term of the contract. By submitting a response to a Collin County solicitation, the vendor will be required to sign the Chapter 2270 Verification form prior to a recommendation of the contract. This Act is effective September 1, 2017.

2.38 Vendors/Contractors/Providers must be in compliance with the provisions of Section 2252.152 and Section 2252.153 of the Texas Government Code which states, in part, contracts with companies engaged in business with Iran, Sudan, or Foreign Terrorist Organizations are prohibited. A governmental entity may not enter into a contract with a company that is listed on the Comptroller of the State of Texas website identified under Section 806.051, Section 807.051 or Section 2253.253 which do business with Iran, Sudan or any Foreign Terrorist Organization. This Act is effective September 1, 2017.

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

1.0 **GENERAL INSTRUCTIONS**

1.0.1 Definitions

1.0.1.1 Offeror: refers to submitter.

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

1.0.1.3 Submittal: refers to those documents required to be submitted to Collin County, by an Offeror.

1.0.1.4 RFP: refers to Request for Proposal.

1.0.1.5 CSP: refers to Competitive Sealed Proposal

1.1 If Offeror does not wish to submit an offer at this time, please submit a No Bid.

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 ionWave Technologies, Inc. (Collin County eBid) 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 submittal may not be withdrawn or canceled by the 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 Proposals/Submittals for any or all products and/or services covered in a Request For Proposal (RFP) and Competitive Sealed Proposal (CSP), 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 RFP's and CSP's submitted in hard copy paper form shall be submitted in a sealed envelope, plainly marked on the outside with the RFP/CSP 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. RFP's and CSP's may be submitted in electronic format via Collin County eBid.

1.9 All Request for Proposals (RFP) and Competitive Sealed Proposals (CSP) submitted electronically via Collin County eBid shall remain locked until official date and time of opening as stated in the Special Terms and Conditions of the RFP and/or CSP.

1.10 Time/date stamp clock in Collin County Purchasing Department shall be the official time of receipt for all Request for Proposals (RFP) and Competitive Sealed Proposals (CSP) submitted in hard copy paper form. RFP's, and CSP's received in the Collin 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 RFP/CSP, 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 a Request for Proposal or 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 Collin County eBid.

1.13.1 Addenda will be transmitted to all that are known to have received a copy of the RFP/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. **Collin County eBid** **https://collincountytx.ionwave.net/**, telephoning Purchasing Department directly, etc.) prior to opening/receipt date and time to insure Offeror's receipt of any addenda issued. 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 Any reference to model/make and/or manufacturer used in specifications is for descriptive purposes only. Products/materials of like quality will be considered.

1.17 Offerors taking exception to the specifications shall do so at their own risk. By offering substitutions, Offeror shall state these exceptions in the section provided in the RFP/CSP 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.

1.18 Minimum Standards for Responsible Prospective Offerors: A prospective Offeror must meet the following minimum requirements:

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

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

1.18.3 have a satisfactory record of performance;

1.18.4 have a satisfactory record of integrity and ethics;

1.18.5 be otherwise qualified and eligible to receive an award.

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

1.20 Vendor shall bear any/all costs associated with it's preparation of a RFP/CSP 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 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.

1.25 Offeror shall comply with all local, state and federal employment and discrimination laws and shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, age, national origin or any other class protected by law.

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. Coverage must be written on occurrence form.

- Each Occurrence: $1,000,000
- Personal Injury & Adv. Injury: $1,000,000
- Products/Completed Operation Aggregate: $2,000,000
- 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 which includes any automobile (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 reporting period. If you choose to have project coverage endorsed onto your base policy, this would be acceptable.

- Each Occurrence/Aggregate: $1,000,000

3.1.5 **Umbrella/Excess Liability** insurance**.**

- Each Occurrence/Aggregate: $1,000,000

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

3.2.1 A waiver of subrogation in favor of Collin County, its officials, employees, volunteers and officers shall be provided for General Liability, Commercial Automobile Liability, and Workers' Compensation.

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

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

3.2.4 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.

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

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

3.3.1 A financial rating of A-VII or higher as assigned by the BEST Rating Company or equivalent.

3.4 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:

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

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

4.0 EVALUATION CRITERIA AND FACTORS

4.1 The award of the contract shall be made to the responsible offeror, whose proposal is determined to be the best evaluated offer resulting from negotiation, taking into consideration the relative importance of price and other factors set forth in the Request for Proposals in accordance with Vernon's Texas Code Annotated, Local Government 262.030.

The Evaluation Committee will review all proposals received by the proposal due date and time as part of a documented evaluation process. For each decision point in the process, the County will evaluate offerors according to specific criteria and will elevate a certain number of offerors to compete against each other. The proposals will be evaluated on the following criteria.

The County will use a competitive process based upon "selection levels." The County recognizes that if an offeror fails to meet expectations during any part of the process, it reserves the right to proceed with the remaining offerors or to elevate an offeror that was not elevated before. The selection levels are described in the following sections.

The first part of the elevation process is to validate the completeness of the proposal and ensure that all the RFP guidelines and submittal requirements are met. Offerors may, at the discretion of the County, be contacted to submit clarifications or additional information within two business days. Incomplete or noncompliant submissions may be disqualified.

LEVEL 1 – CONFORMANCE WITH MANDATORY REQUIREMENTS

Conformance with RFP guidelines and submittal requirements. The following documents shall be submitted as part of the proposal. Failure to provide these documents shall deem vendor as non-responsive.

Criteria evaluated in Level 1:

- Attachment A through C

LEVEL 2 – DETAILED PROPOSAL ASSESSMENT

The Evaluation Committee will conduct a detailed assessment of all proposals elevated to this Level.

Criteria evaluated in Level 2:

CRITERIA	VALUE
Competitiveness of pricing for services proposed (Attachment C)	35
Plan design and the willingness to provide services that meet county needs, including our desire not to carve out or laser employees or exclude medical conditions or treatments that are covered under our medical plan (Attachment B)	30
Financial stability and stop loss coverage experience (Section 6.3.4 and Attachment A)	20
Customer service and claims turnaround time (Attachment B)	5
Demonstrated effectiveness of services provided to other companies, including but not limited to references (RFP Section 6.3.6 and Attachment A)	10
Total	**100**

LEVEL 3 – DEMONSTRATION AND INTERVIEWS (*OPTIONAL*) (MAXIMUM 100 POINTS)

The evaluation committee may hear oral presentations (if desired). Offerors are cautioned, however, that oral presentations are at the sole discretion of the committee and the committee is not obligated to request a demonstration or interview. The oral presentation is an opportunity for the evaluation committee to ask questions and seek clarification of the proposal submitted. The presentation is not meant as an opportunity for the offeror to simply provide generic background information about the corporation or its experience. Thus, the time will be structured with a minimum time for the offeror to present and the majority of time dedicated to addressing questions from the evaluation committee. The oral presentations, if held, will be scheduled accordingly and all presenting offerors will be notified of time and date. The County reserves the right to bypass Level 3 in the evaluation process and move directly to Selection Level 4.

The following criterion is optional and will be used to evaluate those offerors elevated for interviews.

Criteria evaluated in Level 3:

CRITERIA	VALUE
Demonstration/Interview	50
Response to clarification questions	50

LEVEL 4 –BEST AND FINAL OFFER

Offerors who are susceptible of receiving award may be elevated to Level 4 for Best and Final Offer. Offeror will be asked to respond in writing to issues and questions raised by the County as well as any other cost and implementation planning considerations in the proposal, and may be invited to present their responses on-site. Proposals may be re-evaluated based upon Criteria in level 2 and 3.

Based on the result of the Best and Final Offer evaluation, a single offeror will be identified as the finalist for contract negotiations. If a contract cannot be reached after a period of time deemed reasonable by the County, it reserves the right to contact any of the other offerors that have submitted bids and enter into negotiations with them.

5.0 SCOPE OF SERVICES AND SPECIAL CONDITIONS

5.1 Overview: Collin County is conducting a vendor search to select a qualified company to provide medical (including pharmacy) 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.

5.1.1 Collin County has been self-funded for over 15 years. UnitedHealthcare is the current stop loss provider. The medical plan year is January 1st through December 31st. UnitedHealthcare is the current administrator of our medical and pharmacy plan. We do not provide for out-of-network benefits except for lasik, emergency room care, vision, and outpatient mental health benefits. Collin County is committed to self-funding employee benefit plans and keeping our benefit program financially sound. We bid pharmacy separately from medical.

5.1.2 Our current stop loss coverage is a $100,000 12/12 specific plan beginning January 1st and ending December 31st. There is no aggregate coverage currently in place.

5.1.3 There are 1,460 total participants (1,446 are employees, 5 are retirees, and 9 are COBRA participants) enrolled in the medical insurance as of June 30, 2017. Coverage is broken down into the following categories:

- Participant only: 546
- Participant and child: 265
- Participant and spouse: 207
- Participant and family: 442

5.1.3.1 These participants insure another 2,025 individuals as either a spouse or dependent child(ren).

5.1.4 Collin County currently 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. We do not pay secondary coverage for dependents. For retirees over the age of 65, Medicare is considered primary and Collin County is secondary.

5.1.5 Collin County has implemented various cost control methods such as;

- Removing out-of-network coverage,
- Implementing large emergency room co-pays,
- Utilizing an on-site nurse liaison who uses confidential medical information/claims data to identify and work with members who have, or will have, large claim costs or diseases that may be prevented or reduced through disease management programs or by improving employee engagement in health and wellness programs,
- Offering wellness premium discounts and/or lump sum payments to participants that complete specified wellness requirements,
- Implementation of a limited network for pharmacy,
- Offering Centers of Excellence to provide quality treatment for complex medical conditions which generate cost savings to the plan. The most recent offered is a Spine and Joint Center of Excellence.

5.1.6 The following documents are attached for the offerors review:

- Exhibit 1 - 2018 Dual Plan Summary
- Exhibit 2 - 2017 Dual Plan Summary
- Exhibit 3 - 2016 Dual Plan Summary
- Exhibit 4 - Policy Data- Advantage Plan
- Exhibit 5 - Policy Data- Advantage Plus Plan
- Exhibit 6 - Participant Medical Census (08-31-2017)
- Exhibit 7 - 2017 Large Claim Loss with Diagnosis (01-01-2017 through 08-31-2017)
- Exhibit 8 - 2016 Large Claim Loss with Diagnosis
- Exhibit 9 - 2015 Large Claim Loss with Diagnosis
- Exhibit 10 - 2014 Large Claim Loss with Diagnosis

5.2 Authorization: By order of the Commissioner's Court of Collin County, Texas, sealed proposals will be received for RFP No. 2017-365 Insurance, Stop Loss Medical and Pharmacy.

5.3 Intent of Request for Proposal: Collin County's intent of this Request for Proposal (RFP) and resulting contract is to provide offerors with sufficient information to prepare an RFP response for Stop Loss Medical and Pharmacy Insurance coverage.

5.4 Schedule of Events: Collin County reserves the right to change the schedule of events as it deems necessary.

RFP released:	November 9, 2017
Deadline for submission of vendor questions:	November 16, 2017 at 2:00 p.m.
Proposals due:	November 30, 2017 at 2:00 p.m.
Vendor(s) selected contract approved:	December 2017 estimated
Effective date of contract:	January 1, 2018

5.5 Term: Provide for a contract commencing on January 1, 2018, through December 31, 2018.

5.6 Funding: Funds for payment have been provided through the Collin County budget approved by the Commissioners' Court for this fiscal year only. State of Texas statutes prohibit 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.

5.7 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.

5.7.1 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.

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

5.7.3 No vendor has exclusive rights on this account; competitive proposals will be accepted from all responsible offerors.

5.8 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.

5.8.1 Any and all costs, including any set-up costs or termination fees, must be disclosed in **Attachment C - Pricing Information**. The County does not want any bundled charges to be listed. The offeror's response should break down all charges by line item including commissions or fees.

5.9 Negotiations: Discussions may be conducted with responsible offerors who submit proposals determined to be reasonably susceptible of being selected for award. All 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.

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

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

5.9.3 Any oral negotiations must be confirmed in writing prior to award.

5.10 County Assertion of Estimates: Any information herein is provided as an estimate of volume based on past history. This data is provided for the general information of vendors and is not guaranteed to be relied upon for future volumes.

5.11 Price Reduction: 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.

5.12 Approximate Value: The estimated value of this contract is $1,495,141.00 based on 2016 administration fees. Approximate value does not constitute an order.

5.13 Offeror Communication: Offerors are prohibited from communicating directly with any employee of Collin County, except as described herein. Collin County will not be responsible for verbal information given by any Collin County employee. The issuance of an addendum is the only official method whereby interpretation, clarification or additional information will be communicated and authorized further.

5.14 Confidentiality: All completed and submitted proposals become the property of Collin County. Collin County may use the proposal for any purpose it deems appropriate. Prior to Collin County approval, the proposal material is considered as “draft” and is not subject to the Texas “Public Information Act”, Texas Government Code Chapter 552. After approval by Collin County, the proposal material becomes part of the contract between the vendor and Collin County. Upon signing of a contract, proposals and contracts are subject to the State of Texas “Public Information Act”. If any information is to be considered proprietary, the Vendor must place it in a separate envelope and mark it “Proprietary Information”. The State of Texas Attorney General retains the final authority as to the extent of material that is considered proprietary or confidential.

5.15 Binding Effect: This resulting agreement shall be interpreted and enforced under the laws and jurisdiction of the State of Texas. Collin County’s RFP, the offeror’s proposal in response to the RFP and any additional negotiated conditions reduced to writing will become part of the final contract between the successful offeror and Collin County. This agreement then constitutes the entire understanding between the parties and is not subject to amendment unless agreed upon in writing by both parties hereto. By mutual agreement, the parties may, from time to time, promulgate scope of service documents to define the scope of services. Such scope of service documents will

be incorporated into the contract agreement. Offeror acknowledges and agrees that is will perform its obligations hereunder in compliance with all applicable state, local or federal law, rules, regulations, and orders.

6.0 SUBMISSION REQUIREMENTS

6.1 In accordance with the directions below, offeror shall provide a response for each item in sections all of 6.0 and Attachments A through C in order and include item numbers in response. Answer all questions fully, clearly, and concisely, giving complete information. Do not skip items. Do not refer to other parts of your proposal for the answers. If an item is not applicable or the offeror takes exception, offeror shall state that and refer to Section 7.0 Exceptions with explanation.

Offeror shall adhere to the instructions in this request for proposals on preparing and submitting the proposal. If offeror does not follow instructions regarding proposal format, points will be deducted during the evaluation process.

6.2 Point of Contact: Information regarding the purchasing process and the contents of this RFP may be obtained from the Collin County Purchasing Department or email gosinaike@co.collin.tx.us, Geri Osinaike, Senior Buyer.

6.3 Proposal Documents: To be considered, proposals shall be received by 2:00pm. To achieve a uniform review process and to obtain a maximum degree of comparability, Collin County requires that proposals be submitted online via http://collincountytx.ionwave.net or submitted via CD-ROM or Flash Drive. Electronic submissions are preferred.

The proposal shall include a Table of Contents detailing sections and corresponding page numbers. If submitted manually, it shall be printed on letter-size (8-1/2”x 11”) paper and assembled with spiral-type bindings or staples. Responses should have clearly labeled tabs to assist in Collin County’s review. Do not use metal-ring hard cover binders. Paper copies should also be accompanied by an electronic copy of the information provided in a searchable format on a CD or flash drive.

All hardcopy proposals shall be addressed to:

Collin County Purchasing Department
Attn: Geri Osinaike, Senior Buyer
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, STOP LOSS MEDICAL AND PHARMACY
RFP NO. 2017-365

6.3.1 Title Page: Title page shall show the RFP subject, the offeror's name, the name, address, and telephone number of a contact person, and the date of the proposal.

6.3.2 Transmittal Letter: Offeror shall include a signed letter briefly addressing:

- the offeror's understanding of the insurance program being requested,
- the commitment to provide the coverage and services required,
- the length of time the organization has provided stop loss insurance services, and
- a statement explaining why the offeror believes itself to be best qualified to provide the coverage and service detailed within this RFP.

6.3.3 Detailed Proposal: The detailed proposal must address the ability to provide services for each requirement as set forth in the RFP. Answer all questions fully, clearly, and concisely giving complete information. You may not modify the order or language of the question. **You must submit your response in the order that is provided in the RFP.**

Complete the attached documents:

- Attachment A - Stop Loss Questionnaire
- Attachment B - RFP Questionnaire
- Attachment C – Pricing Information

6.3.4 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.**

- 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.
    - 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.
- Financial Information:
    - 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.
- Staff Information:
    - 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.

- 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.

6.3.5 Executive Summary: Please include with your proposal a management summary that outlines the competitive advantages of your proposal. Summarize the key points of the proposal for non-technical, executive review. Please detail any differences between Collin County's current program and the program you offer. If no differences are noted in the executive summary, your program will be deemed to be consistent with Collin County's current program.

6.3.6 Offeror References: References in each category should be unique clients. The offeror shall furnish the following reference information:

6.3.6.1 Date contract terminated, name, address, contact name, email, phone number, position of the contact in the organization, and telephone number for five (5) clients, with at least 1,000 insureds, who have terminated stop loss coverage with your organization in the last six (6) months. If there have been less than five (5) terminations in the last six (6) months, please provide information on the last five (5) terminated clients.

6.3.6.2 Date contract started, name, address, contact name, email, phone number, position of the contact in the organization, and telephone number for five (5) new clients, with at least 1,000 insureds, who have added stop loss coverage with your organization between January and May of this year. If there have been less than five (5) new clients in this time frame, please provide information on the last five (5) new clients.

6.3.6.3 Date of contracts, 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 insureds, and with three (3) or more year's history with the offeror.

6.3.6.4 Date of contracts, name, address, contact name, email, phone number, and 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.

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

6.4 Proposal Guidelines: Under no circumstances should any employee of Collin County or any public official other than those indicated in this RFP, be contacted regarding the RFP 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.

6.4.1 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.

6.4.2 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 UnitedHealthcare proposal). If multiple proposals are submitted, the proposal that is received first will be the proposal that is considered.

6.4.3 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. Each proposal must be fully responsive. If more than one proposal is received, the proposal submitted directly by the insurance company shall be given preference. If more than one response is received for the same insurance company from different brokers, the first complete response received that meets responding requirements will be given preference.

6.4.4 The offeror shall state any and all costs outside of the monthly administration fees such as one-time startup costs in section 7.0 Exceptions.

7.0 EXCEPTIONS

Instructions for completing section:

The exception table shall be completed for any exception from requirements identified in this RFP. Please complete the following worksheet listing any and all exceptions from the information requested in the Request for Proposal. Attach additional pages as needed. If no exceptions are listed in Section 7.0, it is understood that the offeror has agreed to all RFP requirements. The response will be considered as confirmed even if it is listed elsewhere as an exception.

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

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

ATTACHMENT A- STOP LOSS QUESTIONNAIRE

COLLIN COUNTY, TEXAS

INSTRUCTIONS

Answer all questions fully, clearly, and concisely unless a specific question is not applicable 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.

1. GENERAL QUESTIONS

1.1

S&P Rating	
AM Best Rating	

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

_____

_____

_____

_____

1.3 Do you have any current or pending 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? If yes, identify by court and case number.

_____

_____

_____

_____

1.4 Describe any services or any medical cost containment solutions you offer that may help reduce our large cost claims and/or stop loss premiums.

_____

_____

_____

_____

1.5 Describe the process that is to be followed when implementing coverage.

_____

_____

_____

_____

1.6 Describe the procedures that are followed when a contract terminates.

_____

_____

_____

_____

2. <u>TPA COORDINATION QUESTIONS</u>

2.1 Provide a specific outline detailing how your services will coordinate with our health care third party administrator and our pharmacy benefit manager (PBM). Include information required from the health third party administrator and information required from the pharmacy benefit manager, the format in which it can be received, and the timeframe in which it is expected.

_____

_____

_____

_____

2.2 Describe any data/reports/information that you would require from our third party administrator or our pharmacy benefit manager in order to process claims. Please provide the timeframes in which you would need to receive the information.

_____

_____

_____

_____

3. PLAN DESIGN/ADMINISTRATION

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

_____

_____

_____

_____

3.2 Describe any limitations/exclusions you may have regarding filing a claim for reimbursement.

_____

_____

_____

_____

3.3 Describe the circumstances in which a claim or portion of a claim pay be pended. Include a description of the notification that will be made to Collin County.

_____

_____

_____

_____

3.4 Describe the circumstances in which a claim may be denied and the criteria used in making that determination. Include a description of the notification that will be made to Collin County and the process required to reopen and process the claim.

_____

_____

_____

_____

3.5 Describe your resolution process if a claim is denied or pended.

_____

_____

_____

_____

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

_____

_____

_____

_____

3.7 Describe any plan limitations in your 12/12 and 12/15 contracts.

_____

_____

_____

_____

3.8 Describe the information you will need from Collin County in order to properly administer our account and the timeframes in which it must be received.

_____

_____

_____

_____

Attachment B - RFP Questionnaire

Offeror Name:

RFP responders are required to respond to all requests for information contained in this questionnaire. Your responses to the questions should be based on your current proven capabilities. Should there be instances where certain questions are not applicable to your organization or its operations, please indicate this by selecting "N/A". All "No" or "N/A" answers recorded in this questionnaire require additional information. Additional information to accompany those answers MUST be detailed in the Exceptions section (7.0) of your response. If no exceptions are listed in the Exceptions section, it is understood that the offeror has agreed to all requests as listed in the RFP even if discrepancies are listed in other sections. The offeror will be held strictly responsible for all items contained in the specific requirements.

If you are selected to administer this plan, your responses to the questionnaire will be considered part of your contractual responsibilities.

Answer by placing an "X" in the appropriate response column. DO NOT add extra rows/columns.

	General Requirements	Yes	No	N/A
1	Do you agree the contract shall reflect the intent of this RFP and if there is a variance between the two, the RFP will prevail? If the contract does not address an issue covered by the RFP, terms and commitments agreed to in the RFP will be applicable.			
2	Do you agree to list and clearly detail any coverage or service that will not be provided as requested in writing in section 7.0 Exception? It is imperative that any exclusions, limitations, or any other exceptions be clearly outlined and detailed.			
3	Do you agree if no exceptions or alternate responses are listed in the Exceptions section (7.0), it is understood that the offeror has agreed to all requests as listed in the RFP even if discrepancies are listed in other parts of your response? The offeror will be held strictly responsible for all items contained in the specific requirements.			
4	Do you agree that at any time during normal business hours, and as often as the County may deem necessary, to make available to representatives of the County for examination all of your records with respect to all matters covered by the resulting contract, and will permit such representatives of the County to audit, examine, copy, and make excerpts or transcripts from such records, and to make audits of all claims and other data related to all matters covered by the resulting contract all for a period of three (3) years from the date of final settlement of contract or longer period, if any, as may be required by applicable statute or other lawful requirements?			
5	Proposals submitted will be presumed to be in compliance with all applicable laws. Do you agree to comply with federal, state, and local laws and regulations applicable to the plan design, services, and payments for services which are being proposed?			
6	Do you agree to adjust the plan to comply with current and future legislation?			

General Requirements		Yes	No	N/A
7	Do you agree to 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 Collin County or person as a result of the negligent, reckless, or willful acts of omissions by your organization, its officers, agents or employees?			
8	Do you agree not to give away or sell employee data, even "de-identified" data, with or without employee consent?			
9	The offeror acknowledges that it complies with HIPAA standards and has security measures and cyber insurance to protect Collin County and the data maintained in the offeror's electronic systems.			
10	If during the life of the contract, the offeror's net prices to other customers under the same terms and conditions for items/services awarded herein are reduced below the contracted price, the offeror agrees that the benefits of such reduction shall be extended to Collin County.			
11	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.			
12	Offeror agrees that Collin County may have a new account manager assigned to the account at any time, for any reason.			
13	The offeror agrees to work with any currently designated or future third party administrator and pharmacy benefit manager. Our current third party administrator for both medical and pharmacy is currently UnitedHealthcare.			
14	Do you agree to apply all eligible costs paid by the third party administrator within the contract period toward the specific stop loss claim?			
15	Do you agree that all covered employees and their dependents shall not be adversely affected by a change in insurance carriers?			
16	The offeror agrees to reimburse Collin County for 100% of covered medical and pharmacy expenses paid by our third party administrator over the stop loss amount, subject to applicable plan design. If the offeror decides to reimburse Collin County for any amount less than 100% of covered expenses, a written statement detailing the adjustments and the reason for the adjustments will be submitted to Collin County for approval.			
17	The offeror agrees that Collin County shall recover its full self-insured deductible before any recovered subrogation proceeds are distributed to the offeror.			
18	The offeror agrees to process submitted reimbursement claims within 15 days and paid within 30 days from the date of receipt from the County's third party administrator. In no case shall a claim be over 45 days old.			
19	The offeror agrees not to carve out or laser groups or individuals. In addition, they will not place limitations on specific illnesses or physical conditions, nor will they modify the stop loss amount for a specific insured.			
20	Do you agree 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, 2018, and within the contract period?			

General Requirements		Yes	No	N/A
21	The offeror will 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.			
22	The offeror will also provide coverage for "late entrants" into Collin County's health plans, such as new hires and those employees or dependents who experience a qualifying life event.			
23	Stop loss coverage will include the following:			
	A) All employee participants and their covered dependents			
	B) COBRA and Retiree participants and their covered dependents			
	C) Employees who did not continue coverage while on military or FMLA leave but have since returned to work and are covered under the medical plan (These employees are not required to wait an additional 59 days for coverage when they return to work.)			
	D) Employees on family and medical leave			
	E) Employees continuing coverage while on military leave			
	F) COBRA participants who do not receive a timely election notice			
	G) Employees whose FMLA time is not started on time due to administrative error (If such a situation occurs, the offeror will count FMLA time from the date the employee was actually placed on FMLA.)			
	H) Adult children to age 26 as mandated by legislation			
	I) Any coverage required by state or federal law			
24	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.			
25	The offeror agrees to provide monthly and annual status reports listing individuals who have met their deductible, the amount paid, the date paid, and any amounts pended or denied.			
26	The offeror agrees to provide ad hoc reports at no additional cost and/or the ability for the County to run ad hoc reports from the offeror's 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.			
27	The offeror agrees to provide County employees training that is necessary to run reports through the employer website. This also includes any other training related to the stop loss provider that might be requested by the plan administrator. Any costs associated with training must be clearly listed in your response.			
28	The offeror agrees to provide a monthly report showing claim payments made during the month.			
29	The offeror agrees to, at any time during the contract/agreement, supply necessary current and historical data (as determined by Collin County), such as large claim reports and 50% reports, 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 offeror agrees to provide data within 15 business days of the request.			
30	Three months prior to fiscal year end, September 30, will you provide a preliminary accounting on pending claims?			

General Requirements		Yes	No	N/A
31	Collin County self-bills based upon eligible employee count. The offeror agrees to accept Collin County's self-billing each month. Any billing-related documents will be provided to Collin County in electronic format.			
32	Collin County has a standard process for payment of all offerors which requires a 60-day payment grace period from due date of payment. Offeror agrees to the 60-day grace period.			
33	Offer agrees that payment may be made by either wire or check.			
34	The offeror agrees to notify Collin County of any billing/payment issues within 120 days from the date the check was submitted to the offeror. Notice will be made in writing. Any billing/payment issues presented to the county after the 120-day date will not be reviewed or owed.			
35	A notice of cancellation due to error, omission, or payment issue will include a detailed explanation and at least twenty (20) days for Collin County to remedy the situation.			
36	Are there penalties or charges that would apply as a result of contract termination on the anniversary date? Off anniversary/early termination? If "Yes", describe and identify the penalties or charges in Attachment A - Section 4 Financial Information.			
37	Do you agree that 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.			
38	The offeror agrees to respond to County telephone calls and e-mail communications within one (1) business day.			

ATTACHMENT C- PRICING INFORMATION

COLLIN COUNTY, TEXAS

INSTRUCTIONS

Answer all questions fully, clearly, and concisely unless a specific question is not applicable 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.

1. FINANCIAL INFORMATION

4.1 The requested quote for specific stop loss is for a $100,000, 12/12 and 12/15 incurred and paid contract. In addition, please quote a specific stop loss for a $150,000, $200,000, 12/12 and 12/15 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						
Other Fees (describe below)						

4.2 Description of Other Fees from 4.1.

_____

_____

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

_____

_____

COLLIN COUNTY
Medical Plan Summary
Effective January 1, 2018

Benefit	ADVANTAGE Plan	ADVANTAGE PLUS Plan
Physician Services	In-network	In-network
Physician Office Visit	$20 Co-pay	$15 Co-pay
Urgent Care Center Services	$25 Co-pay	$25 Co-pay
Specialist Office Visit	$50 Co-pay	$40 Co-pay
Virtual Visit	$25 Co-pay	$25 Co-pay
Mental Health Services (Outpatient)	$50 Co-pay (Individual) $45 Co-pay (Group)	$40 Co-pay
Office surgery and diagnostic procedures	$20 or $50 copay Plan pays 80%*	$15 or $40 copay Plan pays 75%*
Diabetes Related Physician or Specialist Office Visit	$0 Co-pay	$0 Co-pay
Allergy Shots, Serum and Testing	$20 or $50 Co-pay	Plan pays 75%*
Chiropractic Care	$50 Co-pay	Plan pays 75%* ***($1,000 plan year max)***
Well Care Benefits and Women's Preventive Health Services	Plan pays 100%	Plan pays 100%
Hospital Services		
Emergency Health Services	$500 Co-pay	$500 Co-pay
Inpatient Hospital	Plan pays 80%*	Plan pays 100% after a $100 per day/$500 co-payment maximum*
Mental Health Services (Inpatient)	Plan pays 80%*	Plan pays 75%*
Outpatient Surgery	Plan pays 80%*	Plan pays 100%*
Professional Fees for Surgical and Medical Services	Plan pays 80%*	Plan pays 75%*
Diagnostic/Therapeutic, Laboratory and X-ray Services	Plan pays 80%*	Plan pays 75%*
Additional Services		
Skilled Nursing Facility/Inpatient Physical Rehabilitation	Plan pays 80%*	Plan pays 75%*
Hospice Care or Home Health Care	Plan pays 80%*	Plan pays 100%*
Durable Medical Equipment	Plan pays 80%*	Plan pays 75%*
Emergency Ambulance Services	Plan pays 80%*	Plan pays 75%*
Vision Services		
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)	Vision Insurance (See Vision Summary)	Vision Reimbursement (See Vision Summary)
Prescription Drug Benefits	***Retail (30-day supply***	***Retail (30-day supply)***
Tier 1 (lowest cost option)	20% Co-Insurance / $10 max	20% Co-Insurance / $10 max
Tier 2 (mid-range option)	30% Co-Insurance / $75 max	30% Co-Insurance / $75 max
Tier 3 (highest cost option)	40% Co-Insurance / $200 max	40% Co-Insurance / $200 max
Diabetes Related Prescriptions	$0 Co-pay	$0 Co-pay
Prescription Drug Benefits	***Mail Order (90-day supply)***	***Mail Order (90-day supply)***
Tier 1 (lowest cost option)	20% Co-Insurance/ $20 max	20% Co-Insurance/ $20 max
Tier 2 (higher cost option)	30% Co-Insurance/ $150 max	30% Co-Insurance/ $150 max
Tier 3 (highest cost option)	40% Co-Insurance/ $400 max	40% Co-Insurance/ $400 max
Diabetes Related Prescriptions	$0 Co-pay/ 90 day supply	$0 Co-pay/ 90 day supply
Calendar Year Deductible		
Individual	$750	$250
Family	$1,500	$500
Annual Out-of-Pocket Maximum		
Individual	$4,000	$3,000
Family	$8,000	$6,000

****Deductible applies to those services first and then the co-insurance begins.***

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.

Both plans have limited out-of-network coverage. Please contact Human Resources for more information.

COLLIN COUNTY
Medical Plan Summary
Effective January 1, 2017

Benefit	ADVANTAGE Plan	ADVANTAGE PLUS Plan
Physician Services	In-network	In-network
Physician Office Visit	$20 Co-pay	$15 Co-pay
Urgent Care Center Services	$25 Co-pay	$25 Co-pay
Specialist Office Visit	$50 Co-pay	$40 Co-pay
Virtual Visit	$25 Co-pay	$25 Co-pay
Mental Health Services (Outpatient)	$50 Co-pay (Individual) $45 Co-pay (Group)	$40 Co-pay
Office surgery and diagnostic procedures	$20 or $50 copay Plan pays 80%*	$15 or $40 copay Plan pays 75%*
Diabetes Related Physician or Specialist Office Visit	$0 Co-pay	$0 Co-pay
Allergy Shots, Serum and Testing	$20 or $50 Co-pay	Plan pays 75%*
Chiropractic Care	$50 Co-pay	Plan pays 75%* ***($1,000 plan year max)***
Well Care Benefits and Women's Preventive Health Services	Plan pays 100%	Plan pays 100%
Hospital Services		
Emergency Health Services	$500 Co-pay	$500 Co-pay
Inpatient Hospital	Plan pays 80%*	Plan pays 100% after a $100 per day/$500 co-payment maximum*
Mental Health Services (Inpatient)	Plan pays 80%*	Plan pays 75%*
Outpatient Surgery	Plan pays 80%*	Plan pays 100%*
Professional Fees for Surgical and Medical Services	Plan pays 80%*	Plan pays 75%*
Diagnostic/Therapeutic, Laboratory and X-ray Services	Plan pays 80%*	Plan pays 75%*
Additional Services		
Skilled Nursing Facility/Inpatient Physical Rehabilitation	Plan pays 80%*	Plan pays 75%*
Hospice Care or Home Health Care	Plan pays 80%*	Plan pays 100%*
Durable Medical Equipment	Plan pays 80%*	Plan pays 75%*
Emergency Ambulance Services	Plan pays 80%*	Plan pays 75%*
Vision Services		
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 Vision Summary	See Vision Summary
Prescription Drug Benefits	***Retail***	***Retail***
Tier 1 (lowest cost option)	$10 Co-pay	$10 Co-pay
Tier 2 (mid-range option)	$25 Co-pay	$25 Co-pay
Tier 3 (highest cost option)	$50 Co-pay	$50 Co-pay
Diabetes Related Prescriptions	$0 Co-pay	$0 Co-pay
Prescription Drug Benefits	***Mail Order***	***Mail Order***
Tier 1 (lowest cost option)	$25 Co-pay/ 90 day supply	$25 Co-pay/ 90 day supply
Tier 2 (higher cost option)	$50 Co-pay/ 90 day supply	$50 Co-pay/ 90 day supply
Diabetes Related Prescriptions	$0 Co-pay/ 90 day supply	$0 Co-pay/ 90 day supply
Calendar Year Deductible		
Individual	$750	$250
Family	$1,500	$500
Annual Out-of-Pocket Maximum		
Individual	$3,000	$2,000
Family	$6,000	$4,000

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COLLIN COUNTY
Medical Plan Summary
Effective January 1, 2016

Benefit	ADVANTAGE Plan	ADVANTAGE PLUS Plan
Physician Services	In-network	In-network
Physician Office Visit	$20 Co-pay	$15 Co-pay
Urgent Care Center Services	$25 Co-pay	$25 Co-pay
Specialist Office Visit	$50 Co-pay	$40 Co-pay
Virtual Visit	$25 Co-pay	$25 Co-pay
Mental Health Services (Outpatient)	$50 Co-pay (Individual) $45 Co-pay (Group)	$40 Co-pay
Office surgery and diagnostic procedures	$20 or $50 copay Plan pays 80%*	$15 or $40 copay Plan pays 75%*
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Allergy Shots, Serum and Testing	$20 or $50 Co-pay	Plan pays 75%*
Chiropractic Care	$50 Co-pay	Plan pays 75%* ***($1,000 plan year max)***
Well Care Benefits and Women's Preventive Health Services	Plan pays 100%	Plan pays 100%
Hospital Services		
Emergency Health Services	$500 Co-pay	$500 Co-pay
Inpatient Hospital	Plan pays 80%*	Plan pays 100% after a $100 per day/$500 co-payment maximum*
Mental Health Services (Inpatient)	Plan pays 80%*	Plan pays 75%*
Outpatient Surgery	Plan pays 80%*	Plan pays 100%*
Professional Fees for Surgical and Medical Services	Plan pays 80%*	Plan pays 75%*
Diagnostic/Therapeutic, Laboratory and X-ray Services	Plan pays 80%*	Plan pays 75%*
Additional Services		
Skilled Nursing Facility/Inpatient Physical Rehabilitation	Plan pays 80%*	Plan pays 75%*
Hospice Care or Home Health Care	Plan pays 80%*	Plan pays 100%*
Durable Medical Equipment	Plan pays 80%*	Plan pays 75%*
Emergency Ambulance Services	Plan pays 80%*	Plan pays 75%*
Vision Services		
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 Vision Summary	See Vision Summary
Prescription Drug Benefits	***Retail***	***Retail***
Tier 1 (lowest cost option)	$10 Co-pay	$10 Co-pay
Tier 2 (mid-range option)	$25 Co-pay	$25 Co-pay
Tier 3 (highest cost option)	$50 Co-pay	$50 Co-pay
Diabetes Related Prescriptions	$0 Co-pay	$0 Co-pay
Prescription Drug Benefits	***Mail Order***	***Mail Order***
Tier 1 (lowest cost option)	$25 Co-pay/ 90 day supply	$25 Co-pay/ 90 day supply
Tier 2 (higher cost option)	$50 Co-pay/ 90 day supply	$50 Co-pay/ 90 day supply
Diabetes Related Prescriptions	$0 Co-pay/ 90 day supply	$0 Co-pay/ 90 day supply
Calendar Year Deductible		
Individual	$750	$250
Family	$1,500	$500
Annual Out-of-Pocket Maximum		
Individual	$3,000	$2,000
Family	$6,000	$4,000

****Deductible applies to those services first and then the co-insurance begins.***

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Both plans have limited out-of-network coverage. Please contact Human Resources for more information.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in your medical policy. If there is a difference between this summary and your policy, the terms of your policy will apply.

Providers, this summary is for members, to review the terms of your participation agreement, please visit unitedhealthcareonline.com

POLICY DATA

Policy Holder Name	Collin County
Medical Policy Number	229670
Set Number	007ACIS
Effective Date	03/01/2016
Cancellation Date	99/99/9999
iBAAG Document Author	Vanessie Green
Revision Reason	Maintenance Rework/Human Resource Contact

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN
Health Care Reform	**Summary of Benefits and Coverage (SBC)** ***SBC Creation*** Responsible Party: UHC ***Member Fulfillment*** Responsible Party: Customer ***External Vendor (Carve-out)*** Are external vendor benefits included in SBC? Pharmacy benefits - No Mental Health benefits - No **Expanded Women's Preventive Care Services Apply?** Yes Coverage guidelines for Expanded Women's Preventive Care include: • 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 **Click here for additional information on eligible services covered under the Expanded Women's Preventive Care Services.**
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	**- Urgent Care: UHC** **- 1st Level Pre-Service: UHC** **- 2nd Level Pre-Service: Customer** **- 1st Level Post-Service: UHC** **- 2nd Level Post-Service: Customer** **To Initiate an Appeal-** **For ASO UNET USS and KA customers without Performance Guarantees related to appeals processing and handled in NASC-Oldsmar:** **- Urgent Care - Call Care Coordination** **- 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** **If customer or third party designee conducts the final appeals, indicate exact name and address of entity performing appeals:** **NAME—Collin County** **ADDRESS— 2300 Bloomdale Road, Ste 4117** **McKinney, TX 75071** **The regulation requires that appeals be addressed in the following timeframes based on appeal type:** **- Urgent appeals - 24 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: • 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 For a dependent to be added to the plan when a qualifying event takes place such as marriage the subscriber has **30** days to add the eligible dependent. Do not refer member back to the employer.	An eligible Dependent includes: • 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. 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. 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. To be eligible for coverage under the Policy, a Dependent must reside within the United States.
Dependent Maternity Coverage	**Yes**
Coverage for a Disabled Dependent Child	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: • Is not able to be self-supporting because of mental or physical handicap or disability. • Depends mainly on the Subscriber for support. 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. 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. 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. 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.
Extended Coverage for Total Disability **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.	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:** ● The Total Disability ends. ● **3** months from the date coverage would have ended when the entire Policy was terminated.
Eligibility Contact	UHC
Facility Reasonable Customary	Yes ● 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
Human Resource Contact	Mike Lynn UHC Sales Account Manager **214-561-7859** Michael_d_lynn@uhc.com
Integrated Medical and Disability Support Program	**Not Applicable**
Care Coordination/C2	Not Applicable
Care Coordination	Standard Care Coordination program is a Telephonic Inbound/Outbound case management program in which participants are assisted in meeting their clinical health care needs by a Nurse Case Manager.
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.

<!--section=Deductibles-->

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in your medical policy. If there is a difference between this summary and your policy, the terms of your policy will apply.

Providers, this summary is for members, to review the terms of your participation agreement, please visit unitedhealthcareonline.com

DEDUCTIBLES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Annual Deductible ***Definition of Annual Deductible*** 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. The deductible applies to the service(s) where it is specifically identified in the sections below.	**$750** per Covered Person per calendar year, not to exceed **$1,500** for all Covered Persons in a family.	**$1,250** per Covered Person per calendar year, not to exceed **$2,500** for all Covered Persons in a family.

Per Occurrence Deductible	**Network** **No Per Occurrence Deductible.**	**Non-Network** **No Per Occurrence Deductible.**

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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
Limited Services Counting Method 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 be reduced by the number of days/visits used toward meeting the Annual Deductible.	Benefits which apply visit limitations will apply on the 1st claim.	
Prorated Deductible and Out-of-Pocket	**Does Proration apply? No**	

<!--section=Out_of_Pocket-->

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OUT OF POCKET

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN

	NETWORK	NON-NETWORK
Out-of-Pocket Maximum (OOPM) The Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. 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.	**$3,000** per Covered Person per calendar year, not to exceed **$6,000** for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. **The following costs will never apply to the Out-of-Pocket Maximum:** ● 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 ***Notification Requirements.***	**No Out-of-Pocket Maximum**
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.**	

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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 Reimbursement	**What type of Reimbursement Policy does the plan have?** Reasonable and Customary (R&C) - Professional **How is the allowed amount determined?** • Available data resources of competitive fees in that	

	geographic area. • **80%** of R&C

<!--section=Coinsurance-->

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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)	**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 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. For children, you may designate a pediatrician as the primary care provider. 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.	
Allowed Amount (Eligible Expenses)	You do not have to pay the difference between the ***allowed amount*** and the amount the	You may have to pay the difference between the ***allowed amount*** and the amount the out-

What is an allowed amount? This is the maximum amount that payment is based on for covered health care services. If your doctor charges more than the allowed amount, you may have to pay the difference. **Want more information?** View the glossary for definitions.	network doctor or facility charges. If the doctor does not participate in the network, you may have to pay the difference between the allowed amount and the amount the doctor charged even for emergency services. **How is the allowed amount determined?** This is the contracted fee that we have with your doctor. If the doctor does not have a contract with us, the allowed amount is based on charges for the same or similar services within the geographic market.	of-network doctor charges. **How is the allowed amount determined?** This is based on charges for the same or similar services within the geographic market.
Coinsurance The percentage of Eligible Expenses payable by the plan for certain Covered Health Services after you meet the annual deductible.	**In-Network Plan Level Coinsurance-** **80%** of eligible expenses after satisfying **$750** deductible until Out-of-Pocket is reached.	**Out-of-Network Plan Level Coinsurance-** **60%** of eligible expenses after satisfying **$1,250** deductible until Out-of-Pocket is reached.
Copayment	Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. **Please note that for each designated covered benefit category, you are responsible for paying the lesser of:** ● The applicable Copayment. ● The Eligible Expense. When Copayments apply, please refer to specific benefit category for the reimbursement policy. Details about the way in which Eligible Expenses are determined appear in the benefit category of ***Eligible Expenses*** further below.	

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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		

<!--section=Flexible_Spending_Account-->

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FLEXIBLE SPENDING ACCOUNT

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN
Flexible Spending Account (FSA)	Administered by: **UnitedHealthcare** Your FSA is a **Full Purpose FSA**. ***How does the Full Purpose FSA work?*** The full-purpose FSA lets you set aside money, before taxes, to pay or reimburse yourself for eligible medical, dental, vision and prescription drug expenses. The entire amount you elected to set aside will be available to you on the first day of the plan year. **FSA Carryover** Do unused FSA dollars carryover to the next plan year? **No**
Retiree Reimbursement Account (RRA)	**Not Applicable**
UnitedHealthcare Consumer Accounts Card	**No**

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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		

<!--section=Hospital_Services-->

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HOSPITAL SERVICES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Accessing Benefits	You can choose to receive Network Benefits or Non-Network Benefits. **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. **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. 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. **Health Services from Non-Network Providers Paid as Network Benefits** 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.	
Notification Requirements **Special Note Regarding Medicare** If you are enrolled in Medicare and Medicare pays benefits	**Prior notification is required before you receive certain Covered Health Services.** **You are responsible for notifying us before you receive**	

before the Plan, you are not required to notify us before receiving Covered Health Services.	**the following Covered Health Services:** • 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). • 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 **Please refer to the Mental Health and Substance Use Disorder section for notification requirements pertaining to Mental Health and Substance Use Disorder treatment.** ****REFER TO SPECIFIC BENEFIT SECTION FOR APPLICABLE PENALTIES FOR NOTIFICATION**	**Please refer to the Mental Health and Substance Use Disorder section for notification requirements pertaining to Mental Health and Substance Use Disorder treatment.**
Ambulance Services – Emergency Only Emergency ambulance transportation by a licensed	**Ground Transportation:** **80%** of eligible expenses after satisfying **$750** deductible**.**	**Ground Transportation:** **80%** of eligible expenses after satisfying **$750** Network deductible**.**

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.	. **Air Transportation:** **80%** of eligible expenses after satisfying **$750** deductible**.** **Ground Transportation:** **80%** of eligible expenses after satisfying **$750** deductible**.** **Air Transportation:** **80%** of eligible expenses after satisfying **$750** deductible**.**	**Air Transportation:** **80%** of eligible expenses after satisfying **$750** Network deductible**.** **Ground Transportation:** **80%** of eligible expenses after satisfying **$750** Network deductible**.** **Air Transportation:** **80%** of eligible expenses after satisfying **$750** Network deductible**.**
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: • 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.	**Not Covered**	**Not Covered**
Ambulatory Surgical Center	Refer to ***Surgery Outpatient*** benefit below for a description	Not Covered.

	of Covered Health Services.	
Emergency Health Services-Outpatient 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.	**$500** copay then **100%** of eligible expenses. 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. 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.)	**Same as Network Benefit** 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. 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.) **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 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**.**
Hospital Inpatient Stay 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.) Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose	**80%** of eligible expenses after satisfying **$750** deductible**.**	**Not Covered**

or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described under ***Physician Fees for Surgical and Medical Services.*** Inpatient Stay in a Hospital. Benefits are available for: ● 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. Benefits for Emergency admissions and admissions of less than **24** hours are described under ***Emergency Health Services-Outpatient***, ***Surgery – Outpatient***, ***Scopic Procedures – Diagnostic*** and ***Therapeutic Treatments – Outpatient***, respectively. **UnitedHealth Premium℠ 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: ● 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. 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.		
Lab, X-Ray and Diagnostics – Outpatient 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: • lab and radiology/x-ray; and • mammography 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 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***. Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance.	**80%** of eligible expenses after satisfying **$750** deductible. **80%** of eligible expenses after satisfying **$750** deductible, regardless of place of service.	**Not Covered** **Not Covered**

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 or in a Physician's office. Benefits under this section include: • the facility charge and the charge for supplies and equipment; and • Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under ***Physician Fees for Surgical and Medical Services***. Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance. **<u>Note:</u>** **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.**		
Scopic Procedures – Outpatient Diagnostic and Therapeutic	**80%** of eligible expenses after satisfying **$750** deductible, regardless of place of service.	**Not Covered**

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy. Benefits under this section include: • The facility charge and the charge for supplies and equipment; and • Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under ***Physician Fees for Surgical and Medical Services.*** 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 ***Surgery - Outpatient***. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.		
Surgery-Outpatient The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include:	**80%** of eligible expenses after satisfying **$750** deductible.	**Not Covered**

• 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. Benefits for other Physician services are described under ***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 – Sickness and Injury.*** Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance. **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.**		
Therapeutic Treatments – Outpatient The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a	**80%** of eligible expenses after satisfying **$750** deductible, regardless of place of service.	**Not Covered**

Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology. Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office by appropriately licensed or registered healthcare professionals when: • 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 **Benefits under this section include:** • 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 ***Physician Fees for Surgical and Medical Services*** Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance.		
Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat	**$25** copay per visit, then **100%** of eligible expenses.	**Not Covered**

urgent health care needs are provided in a Physician's office, Benefits are available as described under ***Physician's Office Services – Sickness and Injury.*** 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: • Pharmaceutical Products - Outpatient • Surgery – Outpatient Note - If the service is provided in an Urgent Care Center Setting and the Urgent Care benefit is a flat dollar copayment, then benefits described under the following benefit categories will be subject to the plan copayments deductible and coinsurance in addition to the urgent care center copayment: * Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine – Outpatient * Scopic Procedures - Outpatient Diagnostic and * Therapeutic Treatments		

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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Intensive Care Unit **UnitedHealth Premium℠ Program** UnitedHealthcare designates Network Physicians and	**80%** of eligible expenses after satisfying **$750** deductible**.**	**Not Covered**

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: ● 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. 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.		
Pre-Admission Testing	Refer to the appropriate benefit category. If services are rendered in an outpatient facility refer to the Outpatient Diagnostic benefit, which is described in the ***Surgery - Outpatient*** benefit category. If services are rendered in an office setting refer to the ***Physician's Office Services – Sickness and Injury*** benefit category.	Refer to the appropriate benefit category. If services are rendered in an outpatient facility refer to the Outpatient Diagnostic benefit, which is described in the ***Surgery - Outpatient*** benefit category. If services are rendered in an office setting refer to the ***Physician's Office Services – Sickness and Injury*** benefit category.

<!--section=Maternity_Care-->

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Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Pregnancy – Maternity Services Includes prenatal care, delivery, postnatal care and any related complications. We will pay Benefits for an Inpatient Stay of at least: • **48** hours for the mother and newborn child following a normal vaginal delivery. • **96** hours for the mother and newborn child following a cesarean section delivery. 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. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. 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. **The following services are not covered:**	**Same as:** • ***Physician's Office Services – Sickness and Injury*** • ***Physician Fees*** • ***Hospital-Inpatient Stay*** • ***Lab, X-ray and Diagnostics – Outpatient*** • ***Therapeutic Treatments - Outpatient*** **80%** of eligible expenses after satisfying **$750** deductible.	Not Covered.

• Services provided by a doula (labor aide); • Parenting, pre-natal or birthing classes;		
Neonatal Resource Services (NRS)	Not Applicable	Not Applicable
Newborn Care Non-wellness services for a newborn child whose length of stay in the hospital exceeds the mother's length of stay.	**80%** of eligible expenses after satisfying **$750** deductible.	Not Covered.
Midwife	Covered same as ***Pregnancy - Maternity Services*** and ***Newborn Care*** sections above.	Not Covered.
Birthing Center	Covered same as ***Pregnancy - Maternity Services*** and ***Newborn Care*** sections above.	Not Covered.
The Healthy Pregnancy Program	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. For more information, visit healthy-pregnancy.com or call us toll-free at the number on your health plan ID card.	Not Covered.

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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.	

<!--section=Physician_Services-->

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PHYSICIAN SERVICES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Anesthesia	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 ***Hospital Inpatient Stay***, ***Emergency Health Services - Outpatient*** or ***Surgery – Outpatient*** categories. RAPL services associated with outpatient lab/diagnostics are described under the ***Lab, X-ray and Diagnostics – Outpatient*** benefit.	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 ***Hospital Inpatient Stay***, ***Emergency Health Services - Outpatient*** or ***Surgery – Outpatient*** categories. RAPL services associated with outpatient lab/diagnostics are described under the ***Lab, X-ray and Diagnostics – Outpatient*** benefit.
Hemophilia Program	**The following is excluded from coverage under the Specialty Pharmacy program:**	

	• Hemophilia	
Nutritional Counseling 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. Some examples of such medical conditions include: • Coronary artery disease; • Congestive heart failure; • Severe obstructive airway disease; • Gout; • Renal failure; • Phenylketonuria; and • Hyperlipidemias. The following services are not covered: ● 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: ● Enteral feedings and other nutritional and	**80%** of eligible expenses after satisfying **$750** deductible. When nutritional counseling services are billed as a preventive care service, these services will be paid as described under ***Preventive Care Services***.	Not Covered

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.		
Physician's Office Services – Sickness and Injury 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.	**$20** Primary Physician/ **$50** Specialist copay per visit then **100%** of eligible expenses. No copayment applies when no Physician charge is assessed.	**Not Covered**

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. 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 be subject to the plan deductible and coinsurance in addition to the office visit copayment: · SURGERY, Lab, X-Ray and ALL Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient · Scopic Procedures - Outpatient Diagnostic · Therapeutic Treatments – Outpatient **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: • Pharmaceutical Products - Outpatient Refer to ***Rehabilitation Therapy*** for a description of benefit coverage. **UnitedHealth Premium[SM] 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: ● 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. 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. Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance.		
Preventive Care 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:	**100%** of eligible expenses.	**Non-Network Benefits are not available.**

• 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. Opting out age limits applied to cervical cancer, colorectal cancer screenings, autism screening and covering annual lung cancer screenings.		
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**

Virtual Visit **What is a virtual visit?** Virtual visits are medical visits delivered to you outside of medical facilities by virtual provider clinics that use online technology and live audio/video capabilities. You must pay with a major credit card or debit card at the time of your virtual visit. Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment. **When is virtual visit care**	**$25** copay per visit then **100%** of eligible expenses.	Not Covered

available? Virtual visit is available **24** hours a day, **7** days a week. **Where can I get more information?** To learn more about virtual visit, call the telephone number listed on your health plan ID card. For a list of providers, click on the **Physicians & Facilities** tab on myuhc.com.		
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**

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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** • ***Physician's Office Services*** • ***Physician Fees for Surgical and Medical*** • ***Hospital-Inpatient Stay*** • ***Surgery-Outpatient*** • ***Durable Medical Equipment***	**Not Covered**
Hemophilia Quick Tip	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. • 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 ***Pharmaceutical Products – Outpatient.*** • If administered during an Emergency room visit, refer to ***Emergency Health Services – Outpatient*** for more information. • If self-administered (self-injected, self-infused, etc), refer to ***Prescription Drugs*** for more information. For more information on coverage determination guidelines and codes, please use the **Specialty Pharmacy SOP** link. **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 ***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. • Hemophilia • See ***Specialty Pharmacy Program Quick tip*** 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 Preventive SPI Bundle Job Aid 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.

<!--section=Family_Planning-->

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in your medical policy. If there is a difference between this summary and your policy, the terms of your policy will apply.

Providers, this summary is for members, to review the terms of your participation agreement, please visit unitedhealthcareonline.com

FAMILY PLANNING

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Birth Control Pills	See ***Prescription Drug Section*** for pharmacy benefits.	See ***Prescription Drug Section*** for pharmacy benefits.
ParentSteps(SM)	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. For information concerning infertility treatment, please visit ParentSteps at www.myoptumhealthparentsteps.com or call **1-866-774-4626.**	
Reproductive Resource Services Program (RRS)	**Not Applicable.**	

Infertility Services	**80% of eligible expenses after satisfying $750 deductible.** **The following service is covered:** • **Diagnosis of underlying condition only.** **The following services are not covered:** • **Health services and associated expenses for infertility treatments.** • **Artificial Insemination,** • **GIFT, and ZIFT Office visits are limited to $5,000 per lifetime.**	**Not Covered**
Reproduction 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.	**Same as:** ● ***Physician's Office Services – Sickness and Injury*** ● ***Physician Fees*** ● ***Hospital-Inpatient Stay*** ● ***Lab, X-ray and Diagnostics – Outpatient*** ● ***Therapeutic Treatments - Outpatient*** **Applicable services:** • Voluntary sterilization. • Fetal reduction surgery **Refer to Reproduction-Exclusions for services that are not covered.**	**Not Covered**
Reproduction-Exclusions	**The following services are not covered:** ● 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:** ● ***Physician's Office Services - Sickness and Injury*** ● ***Physician Fees*** ● ***Hospital-Inpatient Stay*** ● ***Surgery - Outpatient***	**Same as:** ● ***Physician's Office Services - Sickness and Injury*** ● ***Physician Fees*** ● ***Hospital-Inpatient Stay*** ● ***Surgery - Outpatient***

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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	**100%** of eligible expenses.	**Non-Network Benefits are not available.**

Benefits as defined under the Health Resources and Services Administration (HRSA) requirement.		
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.**

<!--section=Special_Services-->

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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	**$20** Primary Physician/ **$50** Specialist copay per visit then **100%** of eligible expenses. No copayment applies when no Physician charge is assessed.	**Not Covered**
Bariatric Resource Services (BRS)	Not Applicable.	

Breast Pumps 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. Benefits are only available if breast pumps are obtained from a DME provider or Physician.	**100%** of eligible expenses.	Not Covered.
Cancer Resource Services (CRS)	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. Network benefits are available for patients who receive care at a designated Cancer Resource Services Network facility. 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 before receiving care. For more information and to participate, visit myoptumhealthcomplexmedical.com or call us toll-free at the number on your health plan ID card. Travel and Lodging Assistance is not available as part of the Cancer Resource Services program.	
Chemotherapy	**80%** of eligible expenses after satisfying **$750** deductible.	**Not Covered**
Clinical Trials **What are clinical trials?** A research study that tests new treatments on patients. We cover some routine patient costs for participation in an approved clinical trial if: • You meet the requirements	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category. **Pre-service Notification Requirement** You must notify us as soon as	**Not Covered**

to participate; and • You are referred by a network provider who has said based on medical and scientific information the clinical trial is appropriate for your condition • You have notified us. **What is an approved clinical trial?** A clinical trial that is: • Federally funded or approved; and • Conducted under an investigational drug application reviewed by the Food and Drug Administration (FDA). For all other clinical trials there is no coverage. No coverage for: • Cost for investigational drugs or devices. • Cost for non-health services (for example: travel/transportation) required for you to receive the treatment. • Cost for managing the research. • Items and services provided by the research sponsor free of charge for any person enrolled in the trial. **Want more information?** View the glossary for definitions.	the possibility of participation in a clinical trial arises.	
Congenital Heart Disease Resource Services (CHDRS)	**80%** of eligible expenses after satisfying **$750** deductible**.** 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	**Not Covered**

	include accurate diagnosis, appropriate surgical interventions, higher survival rates and decreased costs. Network benefits are available for patients who receive care at a designated CHD Centers of Excellence Network facility. 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. 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**.	
Dental Services – Accident Only Dental services are covered by the Plan when all of the following are true: • 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 Surgery or a Doctor of Medical Dentistry; and	**80%** of eligible expenses after satisfying **$750** deductible.	**Not Covered**

• 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 procedures; ● 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.		
Durable Medical Equipment The plan pays for Durable Medical Equipment that is: ● 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. 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	**80%** of eligible expenses after satisfying **$750** deductible**.**	**Not Covered**

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		

of chronic or acute respiratory failure or conditions. The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with Durable Medical Equipment. 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. Foot Orthotics -should be covered combined with DME **Notification Required** 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). If you don't notify us, Benefits will be reduced to**50%** of Eligible Expenses		
Foreign Travel **Do not cover flights back to the United States from a foreign country under any circumstance**	**Not covered**	**Not covered**
Healthy Back Program	Not Applicable	
Healthy Weight Program	Not Applicable	

Hearing Aids **Coverage for hearing loss as the result of an accidental injury only.** 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. 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. 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: ● 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.	**50%** of eligible expenses after satisfying **$750** deductible**.** **Coverage for accidental injury only**	**Not covered**
Home Health Care Covered Health Services are services that a Home Health Agency provides if you need	**80%** of eligible expenses after satisfying **$750** deductible**.**	**Not Covered**

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 Care.	**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.	

Custodial Care is defined as services that do not require special skills or training and that: ● 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.		
Hospice Care 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.	**80%** of eligible expenses after satisfying **$750** deductible**.** Benefits are limited to **360** days during the entire period of time you are covered under the Policy.	**Not Covered**
Kidney Disease Programs	Our kidney disease programs provide you: • Nurses you can speak with to help manage your kidney disease • Education and counseling • Help with finding network dialysis centers and doctors	

	For more information or to speak to a nurse advocate, call toll-free at **1-866-561-7518**. TTY users can dial **711**.	
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 Keratecomy (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 Keratecomy (PRK) Â· Radial Keratotomy**
Ostomy Supplies Benefits for ostomy supplies are limited to: ● 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: • 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	**80%** of eligible expenses after satisfying **$750** deductible. .	Not Covered.

Services - Sickness and Injury. 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 Benefits under this section do not include medications for the treatment of infertility		
Private Duty Nursing – Inpatient	Not Covered. **The following service is not covered:** ● Private duty nursing	Not Covered. **The following service is not covered:** ● Private duty nursing
Prosthetic Devices 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: ● artificial arms, legs, feet and hands; ● artificial face, eyes, ears and nose; ● breast prosthesis following mastectomy as required by the Women's Health and	**80%** of eligible expenses after satisfying **$750** deductible.	**Not Covered**

Cancer Rights Act of **1998**, including mastectomy bras and lymphedema stockings for the arm. 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 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 **Notification Required** Please remember that for Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed **$1,000** in cost per device. If you don't obtain prior authorization, Benefits will be reduced to **50%** of Eligible Expenses.		
Reconstructive Procedures 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	**Same as** ● ***Physician's Office Services – Sickness and Injury*** ● ***Physician Fees*** ● ***Hospital-Inpatient Stay*** ● ***Surgery - Outpatient*** ● ***Lab, X-ray and Diagnostics – Outpatient*** ● ***Therapeutic Treatments - Outpatient***	**Not Covered**

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

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. In addition, for Non-Network Benefits you must notify us **24** hours before admission for an Inpatient Stay. If you don't notify us, Benefits will be reduced to **50%** of Eligible Expenses. **Note:** See exclusions described under ***Physical Appearance***.		
Rehabilitation and Habilitative Services Outpatient Therapy and Manipulative Treatment Short-term outpatient rehabilitation services for: • 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. For all rehabilitation services, a licensed therapy provider, under	**$50** copay per visit then **100%** of eligible expenses.	**Not Covered**

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. 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 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. 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. Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance.		
Shoe orthotics	**80%** of eligible expenses after satisfying **$750** deductible. **Shoe orthotics are covered for diagnosis of Diabetes only.**	**Not Covered**
Skilled Nursing Facility Inpatient Rehabilitation Facility Services	**80%** of eligible expenses after satisfying **$750** deductible.	**Not Covered**

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. Benefits for other Physician services, are described under ***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	Benefits are limited to **60** days per calendar year.	

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. **The following services are not covered:** ● Custodial Care. ● Domiciliary care.		
Sleep Disorders including Sleep Apnea	**80%** of eligible expenses after satisfying **$750** deductible. The following services are covered: Medical and surgical treatment for snoring. Appliances for snoring **Limited $5,000 per lifetime.**	**Not Covered**
Transplantation Services 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: • Heart;	**Voluntary** **80%** of eligible expenses after satisfying **$750** deductible. **Travel and Lodging** United Resource Networks will assist the patient and family with travel and lodging arrangements related to: • Congenital Heart Disease (CHD); and • Transplantation services ; and For travel and lodging services to be covered, the patient must be receiving services at a	**Voluntary** Non-Network Benefits are not available.

• 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. 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.	Designated United Resource Networks Facility. 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: • 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	**Not Covered**	**Not Covered**

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Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Alternative Treatments	The following services are not covered: • Acupressure • Acupuncture • Aromatherapy. • Hypnotism. • Massage Therapy. • Rolfing. (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 ***Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.***	
Bereavement Counseling	**80% of eligible expenses after satisfying $750 deductible.**	**Not Covered**
Breast Reconstruction	**Same as** • ***Physician's Office Services – Sickness and Injury*** • ***Physician Fees*** • ***Hospital-Inpatient Stay*** • ***Lab, X-ray and Diagnostics – Outpatient*** • ***Therapeutic Treatments - Outpatient***	**Same as** • ***Physician's Office Services – Sickness and Injury*** • ***Physician Fees*** • ***Hospital-Inpatient Stay*** • ***Lab, X-ray and Diagnostics – Outpatient*** • ***Therapeutic Treatments - Outpatient***

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	**The following services are not covered:**
	• 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 ***Durable Medical Equipment***.
	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.
	• cranial banding;
	• the following items are excluded, even if prescribed by a Physician:
	  • blood pressure cuff/monitor;
	  • enuresis alarm;
	  • non-wearable external defibrillator;
	  • trusses; and
	  • ultrasonic nebulizers;
	• 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;
	
	This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures.	

Diabetes Services **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	**Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care** 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.	Not Covered.

Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes. **Diabetes Self-Management Items** 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 ***Durable Medical Equipment.*** 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 ***Prescription Drugs.*** Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under ***Durable Medical Equipment.*** **Diabetic office visits waive the copay** **Diabetes related labs whether in the office, outpatient, or at a network lab will be covered at 100%, deductible does not apply. Out of network not covered.**	**Diabetes Self-Management Items** Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under ***Durable Medical Equipment*** and ***Prescription Drugs.***	
Dialysis	**80%** of eligible expenses after satisfying **$750** deductible.	**Not Covered.**

Disposable Medical Supplies	Not Covered.	Not Covered.
Drugs	**The following services are not covered under the medical portion of the plan:** ● 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 See ***Prescription Drug*** section for a list of coverages.	
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:
	• 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 ***Diabetes Services*****.** Routine foot care services that are not covered include:
	  • 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:
	  • 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;
	This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes
	
	• Treatment of flat feet;	

	• Treatment of subluxation of the foot.	
Gynecomastia	**The following service is not covered:** • Treatment of benign gynecomastia (abnormal breast enlargement in males.)	

Medical Supplies	**The following services are not covered:**
	• Prescribed or non-prescribed medical and disposable supplies. Examples of supplies that are not covered include, but are not limited to:
	  • 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
	• 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 ***Ostomy Supplies***.
	This exclusion does not apply to:
	  • disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under ***Diabetes Services***;
	  • diabetic supplies for which Benefits are provided as described under ***Diabetes Services***;	

Morbid Obesity	Not Covered.	Not Covered.
Nutrition and Health Education	**The following services are not covered**: • 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 ***Nutritional Counseling***; • 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 Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.	
Orthognathic Surgery	Not Covered.	Not Covered.
Personal Care, Comfort or Convenience	**The following services are not covered:** Supplies, equipment and similar incidentals for personal comfort. Examples include: • Television; • Telephone; • Beauty/barber service • Guest service; Supplies, equipment and similar incidentals for personal comfort. Examples include • 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	**The following services are not covered:** Cosmetic Procedures are excluded. Examples include:	

	• 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, 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..
Procedures and Treatment	**The following services are not covered:** • biofeedback; • 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 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;	
Providers	**The following services are not covered:** Services: • 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: • Prior to ordering the service; or • After the service is received. **This exclusion does not apply to mammography testing.**	
Radiation Therapy		Not Covered.

	80% of eligible expenses after satisfying **$750** deductible**.**	
Services Provided Under Another Plan	**The following services are not covered:** ● Services for which coverage is available: ● Under another plan, except for Eligible Expenses payable as described under ***Coordination of Benefits***; ● 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.	
Smoking Cessation **Limited to $500 per calendar year and $1,000 per lifetime - includes coverage for drugs and related office visits.**	**80%** of eligible expenses after satisfying **$750** deductible**.** **At Office:** **$20** Primary Physician/ **$50** Specialist copay per visit then **100%** of eligible expenses.	Not Covered.
Temporomandibular Joint (TMJ) Services 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. 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 Benefits are provided for surgical treatment if: ● there is clearly demonstrated radiographic evidence of significant joint abnormality;	**Same as** ● ***Physician's Office Services – Sickness and Injury*** ● ***Physician Fees*** ● ***Hospital-Inpatient Stay*** ● ***Surgery - Outpatient*** ● ***Lab, X-ray and Diagnostics – Outpatient*** ● ***Therapeutic Treatments - Outpatient*** limited to $5,000 per lifetime. Coverage is available for the evaluation and treatment of temporomandibular joint syndrome (TMJ), including surgery. **The following services are not covered:** ● Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral	Not Covered.

• non-surgical treatment has failed to adequately resolve the symptoms; and • pain or dysfunction is moderate or severe. Benefits for surgical services include arthrocentesis, arthroscopy, arthoplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include FDA-approved TMJ implants only when all other treatment has failed. Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described under ***Hospital – Inpatient Stay*** and ***Physician Fees for Surgical and Medical Services***, respectively.	appliances, surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.	
Travel	**The following services are not covered:** • 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 ***Travel and Lodging.*** Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.	
Types of Care	**The following services are not covered:** • 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).	
Vision and Hearing	**The following services are not covered:** • routine vision exam, including	**The following services are not covered:** • 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: ● for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or ● 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 **Please refer to *Vision Care* section for a description of covered services for vision.**	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 therapy **Please refer to *Vision Care* section for a description of covered services for vision.**
Wisdom Teeth	Not Covered.	Not Covered.
All Other Exclusions	**The following services are not covered:** ● Autopsies and other coroner services and transportation services for a corpse; ● Charges for: ● 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: ● 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: ● 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; ● 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: ● 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.

<!--section=Prescription_Drugs-->

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in your medical policy. If there is a difference between this summary and your policy, the terms of your policy will apply.

Providers, this summary is for members, to review the terms of your participation agreement, please visit unitedhealthcareonline.com

PRESCRIPTION DRUGS

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Pharmacy Benefit Manager (PBM)	**OptumRx** For all pharmacy support, please refer to the telephone number on the back of your ID card.	
Prescription Drug Definition	Benefits are available for Prescription Drugs at either a Network Pharmacy or a non-Network Pharmacy and are subject to	

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.	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. Benefits for Prescription Drugs are available when the Prescription Drug meets the definition of a Covered Health Service.	
Step Therapy	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. 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.	Coverage up to **31**-day supply. ● **Tier 1: $10** copay then **100%** of eligible expenses. ● **Tier 2: $25** copay then	Not Covered

UnitedHealthcare will determine if the prescription drug is: ● 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 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.	**100%** of eligible expenses. ● **Tier 3: $50** copay then **100%** of eligible expenses. All oral and injectable diabetic medications, diabetic testing supplies, insulin needles, and syringes will be covered at a **$0** copay **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.	
Mail Order Purchases	Coverage up to **90**-day supply ● **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. **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
Health Care Reform	Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined below.	

Preventive Care Medications	**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: • 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 screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. 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.
Specialty Pharmacy Program **Self- administered Diabetes products DO NOT fall into this category**	**Not Applicable – Has not opted into the Specialty Pharmacy Program**

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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
OptumRx **Refer to VCC Desktop for all telephone numbers.**	**Fresh Start Customer** **General Commercial Pharmacy Help Desk (Public Line)** 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) **Prior Authorization Department**	

	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. **OptumRx Mail Service Member Line** 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. **Specialty Pharmacy Patient Care Coordinator Line** ***Prescriber/Member New Prescription or New Services*** 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. **Specialty Pharmacy Patient Care Coordinator Line** ***Prescriber/Member Refill Prescription on Existing Services*** Member can contact this number to refill their specialty medication. Please be aware that this number is for REFILL only. **Doctor to Registered Pharmacist Line** 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. **BPL Number: 66045**
Pharmaceutical Products – Outpatient Quick Tip	**Specialty Medications** Member Services - Refer to the **Specialty Pharmacy SOP** for potential provider prior authorization requirements for drugs covered under the medical plan. Benefit information for Pharmaceutical Products can be located within several applicable areas. Please reference *Specialty Pharmacy* and *Drugs* for additional benefit and exclusion information.
Specialty Pharmacy Program Quick Tip	• The UnitedHealthcare Specialty Pharmacy Program applies to pharmacy benefits **only**. Reference the Customer Service drug list available on PharWeb *(access through customer service SOP)* 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. **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 ***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. • Hemophilia – will be addressed in ***Hemophilia Program*** section • HIV/Aids & Transplant *(exclusion will be for both classes if client has chosen this opt out)* • Oral Oncology Reference the Customer Service drug list available on PharWeb to verify specialty medications typically covered under medical benefits. **Clinical Coverage Review (CCR) team:** Follow standard clinical process for drug review with Medical Policy

<!--section=Other_Benefits-->

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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 For questions call toll free at **1-877-818-5826.** TTY users dial **711**

hi HealthInnovations **™ Hearing Program**	Hearing loss is the third most common chronic condition among older Americans. It is under-diagnosed and treatment is usually expensive. More than **90%** of people with hearing loss can benefit from hearing aids, but do not use them because of the high cost. There is help! Through *hi HealthInnovations*™ and your medical plan. • There is **no cost** to use this program. • You can get high quality, custom-programmed hearing aids for a fraction of the cost for similar devices at other providers. • Your hearing aid is **programmed specifically for you**. • You pay only the discounted price for any hearing aid you buy. • Instead of thousands of dollars, the cost will range from **$599** to **$799** for each hearing aid, based on the hearing aid model you pick. • See the *Hearing Aid Description* below for more details. Each hearing aid comes with: • Free batteries and ear tubes/wax guards that will last most users six months. • A 70-day no-risk trial period. • A one-year manufacturer's warranty. **How to use your Plan Benefits** **1. Ask your health care provider for a hearing test.** To determine if your medical plan pays for a hearing test, call the toll-free number on your ID card. **2. Send us your hearing test results.** If you have had a hearing test done within the past year or once you get a new hearing test, **fax your results** to **(877) 955-4336** or mail them to: UnitedHealthcare P.O. Box 356 Minneapolis, MN 55440 Please include your telephone number and answer these questions: (a) *Have you worn hearing aids before?* (b) *If you have worn hearing aids, what type of hearing aids?* © *Have you worn ear molds before?* **3. Order from a selection of recommended hearing aids.** A week after submitting your test results, call us toll-free at **(866) 926-6632** from **9 a.m.** to **5 p.m.** Central Time, Monday through Friday. You will find out the type of hearing aids that have been recommended for you. At this time you can order your new hearing

	aid. **4. Use follow-up services if needed.** Your hearing aid comes with a 70-day money-back guarantee and free programming adjustments. Call toll-free at **(866) 926-6632** if you need assistance. **Customer Support Services** *hi HealthInnovations*™ offers several support services following your hearing aid purchase. • Education and hearing rehabilitation services over the phone or online. • Hearing health and new-user seminars on topics like effective communication strategies. • Online captioned training videos about using, cleaning and maintaining your hearing aids. To find a hearing professional or for help by phone, call us toll-free at **(866) 926-6632** from **9 a.m.** to **5 p.m.** Central Time, Monday through Friday. **Hearing Aid Description** *hi HealthInnovations*™ hearing aids use advanced technology to improve speech understanding and listening comfort. Each hearing aid is custom-programmed to your specific hearing needs. Every hearing test result and hearing aid order is reviewed by a licensed hearing professional to determine suitability. Hearing aid features include: • **Twelve** gain adjustment bands that are custom-programmed to your hearing needs. • Fully automatic digital algorithms that adapt to the user's environment. • Directional processing that enhances the amplification of the sounds in front of you while reducing distracting background noise from the side and behind. • Comfortable, stylish and discreet design. • Improves your ability to hear electronic devices such as a telephone and audio loops.
Incentives for Health	**NOT APPLICABLE**
Simply Engaged Wellness Incentive Program	**NOT APPLICABLE**
Vision Vendor	Administered by: **UnitedHealthcare Vision**

	• Call **1-800-638-3120** **Please contact UnitedHealthcare Vision to verify eligibility and coverage for routine vision.**

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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.**	

<!--section=Mental_and_Nervous-->

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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** • Call: **1-800-842-5724** **Employee Assistance Program (EAP)** Administered by: Optum • Call: **1-800-842-5724**	Administered by: **United Behavioral Health –Health Plan Division** • Call: **1-800-842-5724** **Employee Assistance Program (EAP)** Administered by: Optum • Call: **1-800-842-5724**

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: ● diagnostic evaluations and assessment; ● treatment planning; ● referral services; ● medication management; ● individual, family, therapeutic group and provider-based case management services; and ● crisis intervention. Benefits include the following services provided on an inpatient basis: ● Partial Hospitalization/Day Treatment; ● services at a Residential Treatment Facility; Benefits include the following services provided on an outpatient basis: ● Intensive Outpatient Treatment; 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. You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.	**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 are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.** **Network provider ONLY will be responsible for obtaining the following notification requirements:** ● 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 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	**Services received on an inpatient basis in a Hospital or Alternate Facility:** **Not Covered.** **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:** ● 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. 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). In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing;

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. 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. 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.	admissions). In addition, **Network provider** must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. ● 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	● extended outpatient treatment visits beyond **45-50** minutes in duration, with or without medication management. If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to **50%** of Eligible Expenses
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following: ● Provided by or under the direction of an experienced	**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**	**Services received on an inpatient basis in a Hospital or Alternate Facility:** **Not Covered.** **Services received on an outpatient basis in a provider's office or at an Alternate Facility:**

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. 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. Benefits include the following services provided on either an outpatient or inpatient basis: ● diagnostic evaluations and assessment; ● treatment planning; ● referral services; ● medication management; ● individual, family, therapeutic group and provider-based case management services; and ● crisis intervention Benefits include the following services provided on an inpatient basis: ● Partial Hospitalization/ Day Treatment ● services at a Residential Treatment Facility. Benefits include the following services provided on an outpatient basis: ● Intensive Outpatient Treatment. The Mental Health/Substance Use Disorder Administrator determines coverage for all	**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 are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.** **Network provider ONLY will be responsible for obtaining the following notification requirements:** ● 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. 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). In addition, **Network provider** must notify the Mental Health/Substance Use Disorder Administrator before the following services are received.	**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: Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorder ~ 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. 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). In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. ● 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. If you fail to notify the Mental Health/Substance Use Disorder

levels of care the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.	• 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	Administrator as required, Benefits will be reduced to **50%** of Eligible Expenses

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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

<!--section=Chemical_Dependency-->

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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** • Call: **1-800-842-5724** **Employee Assistance Program (EAP)** Administered by: Optum • Call: **1-800-842-5724**	Administered by: **United Behavioral Health-HealthPlan Division** • Call: **1-800-842-5724** **Employee Assistance Program (EAP)** Administered by: Optum • Call: **1-800-842-5724**

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: ● diagnostic evaluations and assessment; ● treatment planning; ● referral services; ● medication management; ● individual, family, therapeutic group and provider-based case management; ● crisis intervention. ● detoxification (sub-acute/non-medical); Benefits include the following services provided on an inpatient basis: ● Partial Hospitalization/Day Treatment; ● services at a Residential Treatment Facility; Benefits include the following services provided on an outpatient basis: ● Intensive Outpatient Treatment; The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of carethe inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.	**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 are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.** **Network provider ONLY will be responsible for obtaining the following notification requirements:** ● 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 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	**Services received on an inpatient basis in a Hospital or Alternate Facility:** **Not Covered.** **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:** ● 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. 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). In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. ● intensive outpatient program treatment; ● outpatient electro-convulsive treatment; ● psychological testing; ● extended outpatient treatment visits beyond **45-50**

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care. **Special Substance Use Disorder 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 Substance Use Disorder Services benefit. 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. 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.	for non-scheduled admissions (including Emergency admissions). In addition, **Network provider** must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. ● 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	minutes in duration, with or without medication management. If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to **50%** of Eligible Expenses.

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CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLAN NON-NETWORK
Mental Health and Substance Use Disorder Services	Exclusions listed directly below apply to services described under ***Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders*** **and/or** ***Substance Use Disorders*** **The following services are not covered:** ● Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*; ● 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: ● 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

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POLICY DATA

Policy Holder Name	Collin County
Medical Policy Number	229670
Set Number	006ACIS
Effective Date	03/01/2016
Cancellation Date	99/99/9999
iBAAG Document Author	Sonya Hunter
Revision Reason	Maintenance Rework/ Vision Care

CSR View

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN
Health Care Reform	**Summary of Benefits and Coverage (SBC)** ***SBC Creation*** Responsible Party: UHC ***Member Fulfillment*** Responsible Party: Customer ***External Vendor (Carve-out)*** Are external vendor benefits included in SBC? Pharmacy benefits - No Mental Health benefits - No **Expanded Women's Preventive Care Services Apply?** Yes Coverage guidelines for Expanded Women's Preventive Care include: • 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 **Click here for additional information on eligible services covered under the Expanded Women's Preventive Care**

	Services.
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	**- Urgent Care: UHC** **- 1st Level Pre-Service: UHC** **- 2nd Level Pre-Service: Customer** **- 1st Level Post-Service: UHC** **- 2nd Level Post-Service: Customer** **To Initiate an Appeal-** **For ASO UNET USS and KA customers without Performance Guarantees related to appeals processing and handled in NASC-Oldsmar:** **- Urgent Care - Call Care Coordination** **- 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** **If customer or third party designee conducts the final appeals, indicate exact name and address of entity performing appeals:** **NAME—Collin County** **ADDRESS— 2300 Bloomdale Road, Ste 4117** **McKinney, TX 75071** **The regulation requires that appeals be addressed in the following timeframes based on appeal type:** **- Urgent appeals - 24 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: • 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 For a dependent to be added to the plan when a qualifying event takes place such as marriage the subscriber has **30** days to add the eligible dependent. Do not refer member back to the employer.	An eligible Dependent includes: • 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. 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. 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. To be eligible for coverage under the Policy, a Dependent must reside within the United States.
Dependent Maternity Coverage	**Yes**
Coverage for a Disabled Dependent Child	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: • Is not able to be self-supporting because of mental or physical handicap or disability. • Depends mainly on the Subscriber for support. 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. 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. 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. 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.
Extended Coverage for Total Disability **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.	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:** • The Total Disability ends. • **3** months from the date coverage would have ended when the entire Policy was terminated.

Eligibility Contact	UHC
Facility Reasonable Customary	Yes • 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
Human Resource Contact	Mike Lynn UHC Sales Account Manager **214-561-7859** Michael_d_lynn@uhc.com
Integrated Medical and Disability Support Program	**Not Applicable**
Care Coordination/C2	Not Applicable
Care Coordination	Standard Care Coordination program is a Telephonic Inbound/Outbound case management program in which participants are assisted in meeting their clinical health care needs by a Nurse Case Manager.
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.

<!--section=Deductibles-->

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DEDUCTIBLES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Annual Deductible ***Definition of Annual Deductible*** 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. The deductible applies to the service(s) where it is specifically identified in the sections below.	**$250** per Covered Person per calendar year, not to exceed **$500** for all Covered Persons in a family.	**$500** per Covered Person per calendar year, not to exceed **$1,000** for all Covered Persons in a family.
Per Occurrence Deductible	**Network** **No Per Occurrence Deductible.**	**Non-Network** **No Per Occurrence Deductible.**

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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
Limited Services Counting Method 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 be reduced by the number of days/visits used toward meeting the Annual Deductible.	Benefits which apply visit limitations will apply on the 1st claim.	
Prorated Deductible and Out-of-Pocket	**Does Proration apply? No**	

<!--section=Out_of_Pocket-->

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OUT OF POCKET

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Out-of-Pocket Maximum (OOPM) The Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. 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.	**$2,000** per Covered Person per calendar year, not to exceed **$4,000** for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. **The following costs will never apply to the Out-of-Pocket Maximum:** ● Any charges for non-Covered Health Services. ● The amount of any	**No Out-of-Pocket Maximum**

	reduced Benefits if you don't notify us as described in the section titled ***Notification Requirements.***	
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.**	

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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
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 Reimbursement	**What type of Reimbursement Policy does the plan have?** Reasonable and Customary (R&C) - Professional **How is the allowed amount determined?** • Available data resources of competitive fees in that geographic area. • **80%** of R&C	

<!--section=Coinsurance-->

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COINSURANCE

Situation	2007 ASO CHOICE PLUS	2007 ASO CHOICE PLUS

	PS1 ADVANTAGE PLUS PLAN NETWORK	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 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. For children, you may designate a pediatrician as the primary care provider. 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.	
Allowed Amount (Eligible Expenses) **What is an allowed amount?** This is the maximum amount that payment is based on for covered health care services. If your doctor charges more than the allowed amount, you may have to pay the difference. **Want more information?** View the glossary for definitions.	You do not have to pay the difference between the ***allowed amount*** and the amount the network doctor or facility charges. If the doctor does not participate in the network, you may have to pay the difference between the allowed amount and the amount the doctor charged even for emergency services. **How is the allowed amount determined?** This is the contracted fee that we have with your doctor. If the doctor does not have a contract with us, the allowed amount is based on charges for the same or	You may have to pay the difference between the ***allowed amount*** and the amount the out-of-network doctor charges. **How is the allowed amount determined?** This is based on charges for the same or similar services within the geographic market.

	similar services within the geographic market.	
Coinsurance The percentage of Eligible Expenses payable by the plan for certain Covered Health Services after you meet the annual deductible.	**In-Network Plan Level Coinsurance-** **75%** of eligible expenses after satisfying **$250** deductible until Out-of-Pocket is reached.	**Out-of-Network Plan Level Coinsurance-** **60%** of eligible expenses after satisfying **$500** deductible until Out-of-Pocket is reached.
Copayment	Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. **Please note that for each designated covered benefit category, you are responsible for paying the lesser of:** ● The applicable Copayment. ● The Eligible Expense. When Copayments apply, please refer to specific benefit category for the reimbursement policy. Details about the way in which Eligible Expenses are determined appear in the benefit category of ***Eligible Expenses*** further below.	

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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		

<!--section=Flexible_Spending_Account-->

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FLEXIBLE SPENDING ACCOUNT

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN
Flexible Spending Account (FSA)	Administered by: **UnitedHealthcare** Your FSA is a **Full Purpose FSA**. ***How does the Full Purpose FSA work?***

	The full-purpose FSA lets you set aside money, before taxes, to pay or reimburse yourself for eligible medical, dental, vision and prescription drug expenses. The entire amount you elected to set aside will be available to you on the first day of the plan year. **FSA Carryover** Do unused FSA dollars carryover to the next plan year? **No**
Retiree Reimbursement Account (RRA)	**Not Applicable**
UnitedHealthcare Consumer Accounts Card	**No**

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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		

<!--section=Hospital_Services-->

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HOSPITAL SERVICES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Accessing Benefits	You can choose to receive Network Benefits or Non-Network Benefits. **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.	

	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. 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. **Health Services from Non-Network Providers Paid as Network Benefits** 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.	
Notification Requirements **Special Note Regarding Medicare** 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.	**Prior notification is required before you receive certain Covered Health Services.** **You are responsible for notifying us before you receive the following Covered Health Services:** • 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). • 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	

	Please refer to the Mental Health and Substance Use Disorder section for notification requirements pertaining to Mental Health and Substance Use Disorder treatment. ****REFER TO SPECIFIC BENEFIT SECTION FOR APPLICABLE PENALTIES FOR NOTIFICATION**	**Please refer to the Mental Health and Substance Use Disorder section for notification requirements pertaining to Mental Health and Substance Use Disorder treatment.**
Ambulance Services – Emergency Only 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. **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: • From a non-Network Hospital to a Network Hospital; • To a Hospital that provides a	**Ground Transportation:** **75%** of eligible expenses after satisfying **$250** deductible**.** **.** **Air Transportation:** **75%** of eligible expenses after satisfying **$250** deductible**.** **Ground Transportation:** **75%** of eligible expenses after satisfying **$250** deductible**.** **Air Transportation:** **75%** of eligible expenses after satisfying **$250** deductible**.** **Not Covered**	**Ground Transportation:** **75%** of eligible expenses after satisfying **$250** Network deductible**.** **Air Transportation:** **75%** of eligible expenses after satisfying **$250** Network deductible**.** **Ground Transportation:** **75%** of eligible expenses after satisfying **$250** Network deductible**.** **Air Transportation:** **75%** of eligible expenses after satisfying **$250** Network deductible**.** **Not Covered**

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.		
Ambulatory Surgical Center	Refer to ***Surgery Outpatient*** benefit below for a description of Covered Health Services.	Refer to ***Surgery Outpatient*** benefit below for a description of Covered Health Services.
Emergency Health Services-Outpatient 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.	**$500** copay then **100%** of eligible expenses. 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. 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.)	**Same as Network Benefit** 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. 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.) **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 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**.**
Hospital Inpatient Stay If a Covered Person is confined in a private Hospital room, the difference between the cost of a	**100%** after **$250** Deductible has been met and you pay a **$100** Copayment per day (Maximum **5** days)	**Not Covered**

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.) 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 ***Physician Fees for Surgical and Medical Services.*** Inpatient Stay in a Hospital. Benefits are available for: ● 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. Benefits for Emergency admissions and admissions of less than **24** hours are described under ***Emergency Health Services-Outpatient***, ***Surgery – Outpatient***, ***Scopic Procedures – Diagnostic*** and ***Therapeutic Treatments – Outpatient***, respectively. **UnitedHealth Premium℠ 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: ● 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. 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.		
Lab, X-Ray and Diagnostics – Outpatient 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: • lab and radiology/x-ray; and • mammography 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 in this section under ***Physician Fees for Surgical and Medical***	**75%** of eligible expenses after satisfying **$250** deductible.	**Not Covered**

Services. Lab, X-ray and diagnostic services for preventive care are described under ***Preventive Care Services***. Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance. **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 or in a Physician's office. Benefits under this section include: • the facility charge and the charge for supplies and equipment; and • Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under ***Physician Fees for Surgical and Medical Services***. Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance. **<u>Note:</u>** **Radiology notification required for outpatient MRI/MRA Scans, CT Scans, PET Scans and Nuclear Medicine Studies for services rendered by a Network**	**75%** of eligible expenses after satisfying **$250** deductible, regardless of place of service.	**Not Covered**

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.		
Scopic Procedures – Outpatient Diagnostic and Therapeutic The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office . Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy. Benefits under this section include: • The facility charge and the charge for supplies and equipment; and • Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under ***Physician Fees for Surgical and Medical Services.*** 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 ***Surgery - Outpatient***. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy,	**75%** of eligible expenses after satisfying **$250** deductible.	**Not Covered**

hysteroscopy.		
Surgery-Outpatient The Plan pays for surgery and related 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 • Certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy) • Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under ***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 – Sickness and Injury.*** Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance. **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**	**Facility Charges:** **100%** of eligible expenses after satisfying **$250** deductible**.** **Physician services**: **75%** of eligible expenses after satisfying **$250** deductible.	**Not Covered**

Providers Only - please select the "Radiology/ Notification prompt when confirming benefits for these services.		
Therapeutic Treatments – Outpatient The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology. Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office by appropriately licensed or registered healthcare professionals when: • 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 **Benefits under this section include:** • 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 ***Physician Fees for Surgical and Medical Services***	**75%** of eligible expenses after satisfying **$250** deductible, regardless of place of service.	**Not Covered.**

Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance.		
Urgent Care Center Services 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 ***Physician's Office Services – Sickness and Injury.*** 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: • Pharmaceutical Products - Outpatient • Surgery – Outpatient Note - If the service is provided in an Urgent Care Center Setting and the Urgent Care benefit is a flat dollar copayment, then benefits described under the following benefit categories will be subject to the plan copayments deductible and coinsurance in addition to the urgent care center copayment: * Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine – Outpatient * Scopic Procedures - Outpatient Diagnostic and * Therapeutic Treatments	**$25** copay per visit, then **100%** of eligible expenses.	**Not Covered**

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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
Intensive Care Unit **UnitedHealth Premium℠ 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: ● 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. 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.	**100% after $250 Deductible has been met and you pay a $100 Copayment per day (Maximum 5 days)**	**Not Covered**
Pre-Admission Testing	Refer to the appropriate benefit category. If services are rendered in an outpatient facility refer to the Outpatient Diagnostic benefit, which is described in the ***Surgery - Outpatient*** benefit category. If services are rendered in an office setting refer to the	**Not Covered**

	Physician's Office Services – Sickness and Injury benefit category.	

<!--section=Maternity_Care-->

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MATERNITY CARE

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Pregnancy – Maternity Services Includes prenatal care, delivery, postnatal care and any related complications. We will pay Benefits for an Inpatient Stay of at least: • **48** hours for the mother and newborn child following a normal vaginal delivery. • **96** hours for the mother and newborn child following a cesarean section delivery. 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. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Both before and during a	**Same as:** • ***Physician's Office Services – Sickness and Injury*** • ***Physician Fees*** • ***Hospital-Inpatient Stay*** • ***Lab, X-ray and Diagnostics – Outpatient*** • ***Therapeutic Treatments - Outpatient*** **75%** of eligible expenses after satisfying **$250** deductible. 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.	**Not Covered**

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. **The following services are not covered:** • Services provided by a doula (labor aide); • Parenting, pre-natal or birthing classes;		
Neonatal Resource Services (NRS)	Not Applicable	Not Applicable
Newborn Care Non-wellness services for a newborn child whose length of stay in the hospital exceeds the mother's length of stay.	**75%** of eligible expenses after satisfying **$250** deductible.	**Not Covered**
Midwife	Covered same as ***Pregnancy - Maternity Services*** and ***Newborn Care*** sections above.	**Not Covered**
Birthing Center	Covered same as ***Pregnancy - Maternity Services*** and ***Newborn Care*** sections above.	**Not Covered**
The Healthy Pregnancy Program	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.	**Not Covered**

	For more information, visit healthy-pregnancy.com or call us toll-free at the number on your health plan ID card.	

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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
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.	

<!--section=Physician_Services-->

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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., radiologists, anesthesiologists, pathologists, labs, emergency room physicians) are covered as part of the facility benefit as described under ***Hospital Inpatient Stay***, ***Emergency Health Services - Outpatient*** or ***Surgery – Outpatient*** categories. RAPL services associated with outpatient lab/diagnostics are described under the ***Lab, X-ray and Diagnostics – Outpatient*** benefit.	**Not Covered**

Hemophilia Program	**The following is excluded from coverage under the Specialty Pharmacy program:** • Hemophilia	
Nutritional Counseling 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. Some examples of such medical conditions include: • Coronary artery disease; • Congestive heart failure; • Severe obstructive airway disease; • Gout; • Renal failure; • Phenylketonuria; and • Hyperlipidemias. The following services are not covered: ● 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: ● Enteral feedings and other nutritional and electrolyte formulas, including infant formula	**75%** of eligible expenses after satisfying **$250** deductible. When nutritional counseling services are billed as a preventive care service, these services will be paid as described under ***Preventive Care Services***. **Nutritional Education:** **$15** per office visit with Primary Physician or **$40** per office visit with Specialist, then **100%** of eligible expenses.	Not Covered

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.		
Physician's Office Services – Sickness and Injury 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	**$15** Primary Physician/ **$40** Specialist copay per visit then **100%** of eligible expenses. No copayment applies when no Physician charge is assessed.	**Not Covered**

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. 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 be subject to the plan deductible and coinsurance in addition to the office visit copayment: · SURGERY, Lab, X-Ray and ALL Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient · Scopic Procedures - Outpatient Diagnostic · Therapeutic Treatments - Outpatient **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: • Pharmaceutical Products – Outpatient Refer to ***Rehabilitation Therapy*** for a description of benefit coverage. **UnitedHealth Premium℠ 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: ● 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. 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. Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance.		
Preventive Care 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: • evidence-based items or services that have in effect a	**100%** of eligible expenses.	**Non-Network Benefits are not available.**

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. Opting out age limits applied to cervical cancer, colorectal cancer screenings, autism screening and covering annual lung cancer screenings.		
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.	**75%** of eligible expenses after satisfying **$250** deductible.	**Not Covered**
Second Surgical Opinion This is not a required service to obtain benefits.	**Physician Office Services:** **$15** copay per visit then **100%** of eligible expenses. **Specialist Office Services:** **$40**copay per visit then **100%** of eligible expenses.	**Not Covered**
Virtual Visit **What is a virtual visit?** Virtual visits are medical visits delivered to you outside of medical facilities by virtual provider clinics that use online technology and live audio/video capabilities. You must pay with a major credit card or debit card at the time of your virtual visit. Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment. **When is virtual visit care available?** Virtual visit is available **24** hours a day, **7** days a week. **Where can I get more information?** To learn more about virtual visit, call the telephone number listed on your health plan ID	**$25** copay per visit then **100%** of eligible expenses.	Not Covered

card. For a list of providers, click on the **Physicians & Facilities** tab on myuhc.com.		
Vision Care	**50%** of eligible expenses after satisfiying **$25** Deductible per calendar year **$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 per covered person per calendar year. Contacts limited to one pair person per calendar year.Disposable contacts covered up to a years supply.	**50%** of eligible expenses after satisfiying **$25** Deductible per calendar year Same as Network Benefit (Plan Pays **50%**)

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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** • ***Physician's Office Services*** • ***Physician Fees for Surgical and Medical*** • ***Hospital-Inpatient Stay*** • ***Surgery-Outpatient*** • ***Durable Medical Equipment***	**Not Covered**
Hemophilia Quick Tip	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.	

	• 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 ***Pharmaceutical Products – Outpatient.*** • If administered during an Emergency room visit, refer to ***Emergency Health Services – Outpatient*** for more information. • If self-administered (self-injected, self-infused, etc), refer to ***Prescription Drugs*** for more information. For more information on coverage determination guidelines and codes, please use the **Specialty Pharmacy SOP** link. **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 ***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. • Hemophilia • See ***Specialty Pharmacy Program Quick tip*** 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 Preventive SPI Bundle Job Aid 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.

<!--section=Family_Planning-->

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in your medical policy. If there is a difference between this summary and your policy, the terms of your policy will apply.

Providers, this summary is for members, to review the terms of your participation agreement, please visit unitedhealthcareonline.com

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 ***Prescription Drug Section*** for pharmacy benefits.	See ***Prescription Drug Section*** for pharmacy benefits.
ParentSteps(SM)	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. For information concerning infertility treatment, please visit ParentSteps at www.myoptumhealthparentsteps.com or call **1-866-774-4626.**	
Reproductive Resource Services Program (RRS)	**Not Applicable.**	
Infertility Services	**75%** of eligible expenses after satisfying **$250** deductible.	**Not Covered**

	The following service is covered: ● Diagnosis of underlying condition only. **The following services are not covered:** ● Health services and associated expenses for infertility treatments. ● Artificial Insemination, ● GIFT, and ● ZIFT Office visits are limited to **$5,000** per lifetime**.**	
Reproduction 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.	**Same as:** ● ***Physician's Office Services – Sickness and Injury*** ● ***Physician Fees*** ● ***Hospital-Inpatient Stay*** ● ***Lab, X-ray and Diagnostics – Outpatient*** ● ***Therapeutic Treatments - Outpatient*** **Applicable services:** • Voluntary sterilization. • Fetal reduction surgery **Refer to Reproduction-Exclusions for services that are not covered.**	**Not Covered**
Reproduction-Exclusions	**The following services are not covered:** ● The following infertility treatment-related services: ● 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; 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:** • ***Physician's Office Services - Sickness and Injury*** • ***Physician Fees*** • ***Hospital-Inpatient Stay*** • ***Surgery - Outpatient***	**Not Covered.**

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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
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	**100%** of eligible expenses.	**Non-Network Benefits are not available.**

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.		

<!--section=Special_Services-->

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SPECIAL SERVICES

Situation	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NETWORK	2007 ASO CHOICE PLUS PS1 ADVANTAGE PLUS PLAN NON-NETWORK
Acupuncture Services 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. • Doctor of Medicine; • Doctor of Osteopathy; • Chiropractor; or • Acupuncturist.	**75%** of eligible expenses after satisfying **$250** deductible. Benefits are limited to **$1,000** per calendar year. Needle Therapy and all other services covered by acupuncturist covered up to **$1,000** max.	Not Covered.
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.	
Breast Pumps 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. Benefits are only available if breast pumps are obtained from a DME provider or Physician.	**100%** of eligible expenses.	Not Covered.
Cancer Resource Services (CRS)	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. Network benefits are available for patients who receive care at a designated Cancer Resource Services Network facility. 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 before receiving care. For more information and to participate, visit myoptumhealthcomplexmedical.com or call us toll-free at the number on your health plan ID card. Travel and Lodging Assistance is not available as part of the Cancer Resource Services program.	
Chemotherapy	**75%** of eligible expenses after satisfying **$250** deductible.	**Not Covered.**
Clinical Trials **What are clinical trials?** A research study that tests new treatments on patients.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category.	**Not Covered**

We cover some routine patient costs for participation in an approved clinical trial if: • You meet the requirements to participate; and • You are referred by a network provider who has said based on medical and scientific information the clinical trial is appropriate for your condition • You have notified us. **What is an approved clinical trial?** A clinical trial that is: • Federally funded or approved; and • Conducted under an investigational drug application reviewed by the Food and Drug Administration (FDA). For all other clinical trials there is no coverage. No coverage for: • Cost for investigational drugs or devices. • Cost for non-health services (for example: travel/transportation) required for you to receive the treatment. • Cost for managing the research. • Items and services provided by the research sponsor free of charge for any person enrolled in the trial. **Want more information?** View the glossary for definitions.	**Pre-service Notification Requirement** You must notify us as soon as the possibility of participation in a clinical trial arises.	
Congenital Heart Disease Resource Services (CHDRS)	**100% after $250 Deductible has been met and you pay a $100 Copayment per day (Maximum 5 days)** Access to the CHD Centers of Excellence Network gives	**Not Covered**

	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. Network benefits are available for patients who receive care at a designated CHD Centers of Excellence Network facility. 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. 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**.	
Dental Services – Accident Only Dental services are covered by the Plan when all of the following are true: • 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 Surgery or a Doctor of	**75%** of eligible expenses after satisfying **$250** deductible.	**Not Covered**

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 procedures;		

● 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.		
Durable Medical Equipment The plan pays for Durable Medical Equipment that is: ● 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. 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 unit. If you rent or purchase a	**75%** of eligible expenses after satisfying **$250** deductible**.**	**Not Covered**

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 respiratory failure or		

conditions. The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with Durable Medical Equipment. 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. Foot Orthotics -should be covered combined with DME **Notification Required** 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). If you don't notify us, Benefits will be reduced to**50%** of Eligible Expenses		
Foreign Travel **Do not cover flights back to the United States from a foreign country under any circumstance.**	**Not covered**	**Not covered**
Healthy Back Program	Not Applicable	
Healthy Weight Program	Not Applicable	
Hearing Aids **Coverage for hearing loss as**	**50%** of eligible expenses after	**Not Covered**.

the result of an accidental injury only. 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. 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. 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: ● 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.	satisfying **$250** deductible**.** **Coverage for accidental injury only**	
Home Health Care Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the	**100%** of eligible expenses after satisfying **$250** deductible**.** **The following services are not**	**Not Covered**

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.	

Custodial Care is defined as services that do not require special skills or training and that: ● 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.		
Hospice Care 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.	**100%** of eligible expenses after satisfying **$250** deductible. Benefits are limited to **180** days during the entire period of time you are covered under the Policy.	**Not Covered**
Kidney Disease Programs	Our kidney disease programs provide you: • Nurses you can speak with to help manage your kidney disease • Education and counseling • Help with finding network dialysis centers and doctors	

	For more information or to speak to a nurse advocate, call toll-free at **1-866-561-7518**. TTY users can dial **711**.	
Lasik surgery	**50%** of billed charges, limited to **$2,000** lifetime, combined in and out-of-network. The following services are not covered: • Photo Refractive Keratecomy (PRK) • Radial Keratotomy	**50%** of billed charges, limited to **$2,000** lifetime, combined in and out-of-network. The following services are not covered: • Photo Refractive Keratecomy (PRK) • Radial Keratotomy
Ostomy Supplies Benefits for ostomy supplies are limited to: ● 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.	**75%** of eligible expenses after satisfying **$250** 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: • inhaled medication in an urgent care center for treatment of an asthma attack.	**75%** of eligible expenses after satisfying **$250** deductible. .	Not Covered.

When these services are performed in a Physician's office, Benefits are described under ***Physician's Office Services - Sickness and Injury.*** 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		
Private Duty Nursing – Inpatient	Not Covered. **The following service is not covered:** ● Private duty nursing	Not Covered. **The following service is not covered:** ● Private duty nursing
Prosthetic Devices 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: ● 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**, including mastectomy bras and lymphedema stockings	**75%** of eligible expenses after satisfying **$250** deductible.	**Not Covered**

for the arm. 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 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 **Notification Required** Please remember that for Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed **$1,000** in cost per device. If you don't obtain prior authorization, Benefits will be reduced to **50%** of Eligible Expenses.		
Reconstructive Procedures 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 with an Injury, Sickness or Congenital Anomaly. The	**Same as** ● ***Physician's Office Services – Sickness and Injury*** ● ***Physician Fees*** ● ***Hospital-Inpatient Stay*** ● ***Surgery - Outpatient*** ● ***Lab, X-ray and Diagnostics – Outpatient*** ● ***Therapeutic Treatments - Outpatient*** You can contact us at the telephone number on your ID	**Same as** ● ***Physician's Office Services – Sickness and Injury*** ● ***Physician Fees*** ● ***Hospital-Inpatient Stay*** ● ***Surgery - Outpatient*** ● ***Lab, X-ray and Diagnostics – Outpatient*** ● ***Therapeutic Treatments - Outpatient*** You can contact us at the telephone number on your ID

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 procedure is performed. When	card for more information about Benefits for mastectomy related services.	card for more information about Benefits for mastectomy related services.

you provide notification, we can determine whether the service is considered reconstructive or cosmetic. Cosmetic procedures are always excluded from coverage. In addition, for Non-Network Benefits you must notify us **24** hours before admission for an Inpatient Stay. If you don't notify us, Benefits will be reduced to **50%** of Eligible Expenses. **Note:** See exclusions described under ***Physical Appearance***.		
Rehabilitation and Habilitative Services Outpatient Therapy and Manipulative Treatment Short-term outpatient rehabilitation services for: • 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. 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. The Plan will pay Benefits for	**75%** of eligible expenses after satisfying **$250** deductible.	**Not Covered**

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 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. 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. Outpatient Surgery, Therapeutic Treatments, Major and Minor lab services, and rehab services performed in an office setting will be subject to deductibles and co-insurance.		
Shoe Orthotics	**75%** of eligible expenses after satisfying **$250** deductible. **Shoe orthotics are covered for diagnosis of Diabetes only.**	**Not Covered**
Skilled Nursing Facility **Inpatient Rehabilitation Facility Services** **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	**75%** of eligible expenses after satisfying **$250** deductible. Benefits are limited to **60** days per calendar year.	**Not Covered**

radiologists. Benefits for other Physician services, are described under ***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 and effectively. **The following services are not covered:** ● Custodial Care. ● Domiciliary care.		
Sleep Disorders including Sleep Apnea	The following services are covered: Medical and surgical treatment for snoring. Appliances for snoring **75%** of eligible expenses after satisfying **$250** deductible. limited to, **$5,000** per lifetime	**Not Covered**
Spinal/Manipulative Treatment	**75%** of eligible expenses after satisfying **$250** deductible. Benefits for Spinal Treatment are limited to **$1,000** per calendar year.	**Not Covered**
Transplantation Services 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: • Heart; • Heart/lung; • Lung; • Kidney; • Kidney/pancreas;	**Voluntary** **100%** of eligible expenses. **Travel and Lodging** United Resource Networks will assist the patient and family with travel and lodging arrangements related to: • Congenital Heart Disease (CHD); and • Transplantation services ; and For travel and lodging services to be covered, the patient must be receiving services at a Designated United Resource Networks Facility. The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a	**Voluntary** Non-Network Benefits are not available.

• 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. 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.	companion as follows: • 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.**

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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
Alternative Treatments	The following services are not covered: • Acupressure • Aromatherapy. • Hypnotism. • Massage Therapy. • Rolfing. (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 ***Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.***	
Bereavement Counseling	**75% of eligible expenses after satisfying $250 deductible**	**Not Covered**
Breast Reconstruction	**Same as** • ***Physician's Office Services – Sickness and Injury*** • ***Physician Fees*** • ***Hospital-Inpatient Stay*** • ***Lab, X-ray and Diagnostics – Outpatient*** • ***Therapeutic Treatments - Outpatient***	**Same as** • ***Physician's Office Services – Sickness and Injury*** • ***Physician Fees*** • ***Hospital-Inpatient Stay*** • ***Lab, X-ray and Diagnostics – Outpatient*** • ***Therapeutic Treatments - Outpatient***
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	**The following services are not covered:**
	• 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 ***Durable Medical Equipment***.
	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.
	• cranial banding;
	• the following items are excluded, even if prescribed by a Physician:
	  • blood pressure cuff/monitor;
	  • enuresis alarm;
	  • non-wearable external defibrillator;
	  • trusses; and
	  • ultrasonic nebulizers;
	• 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;
	
	This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures.	

Diabetes Services **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. Benefits under this section also include medical eye	**Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care** 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. **Diabetes Self-Management Items** Depending upon where the Covered Health Service is provided, Benefits for diabetes	**Not Covered**

examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes. **Diabetes Self-Management Items** 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 ***Durable Medical Equipment.*** 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 ***Prescription Drugs.*** Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under ***Durable Medical Equipment.*** **Diabetic office visits waive the copay** **Diabetes related labs whether in the office, outpatient, or at a network lab will be covered at 100%, deductible does not apply. Out of network not covered.**	self-management items will be the same as those stated under ***Durable Medical Equipment*** and ***Prescription Drugs.***	
Dialysis	**75%** of eligible expenses after satisfying **$250** deductible.	**Not Covered**
Disposable Medical Supplies	Not Covered.	Not Covered.
Drugs	**The following services are not covered under the medical**	

	portion of the plan: • 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 See ***Prescription Drug*** section for a list of coverages.	
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:
	• 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 ***Diabetes Services*****.** Routine foot care services that are not covered include:
	  • 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:
	  • 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;
	This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes
	
	• Treatment of flat feet;
	• Treatment of subluxation of the foot.	

Gynecomastia	**The following service is not covered:** • Treatment of benign gynecomastia (abnormal breast	

	enlargement in males.)	

Medical Supplies	**The following services are not covered:**
	• Prescribed or non-prescribed medical and disposable supplies. Examples of supplies that are not covered include, but are not limited to:
	  • 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 ***Ostomy Supplies***.
	This exclusion does not apply to:
	  • ostomy bags and related supplies for which Benefits are provided as described under ***Ostomy Supplies***;
	  • disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under ***Diabetes Services***;
	  • diabetic supplies for which Benefits are provided as described under ***Diabetes Services***;	

Morbid Obesity	Not Covered	Not Covered
Nutrition and Health Education	**The following services are not covered**: • 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 ***Nutritional Counseling***; • 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 Health education classes unless offered by UnitedHealthcare or its	

	affiliates, including but not limited to asthma, smoking cessation, and weight control classes.	
Orthognathic Surgery	Not Covered.	Not Covered.
Personal Care, Comfort or Convenience	**The following services are not covered:** Supplies, equipment and similar incidentals for personal comfort. Examples include: • Television; • Telephone; • Beauty/barber service • Guest service; Supplies, equipment and similar incidentals for personal comfort. Examples include • 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	**The following services are not covered:** Cosmetic Procedures are excluded. Examples include: • 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, 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..
Procedures and Treatment	**The following services are not covered:** • biofeedback; • 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 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*;*	
Providers	**The following services are not covered:** Services: • 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: • Prior to ordering the service; or • After the service is received. **This exclusion does not apply to mammography testing.**	
Radiation Therapy	**75%** of eligible expenses after satisfying **$250** deductible**.**	Not Covered.
Services Provided Under	**The following services are not covered:**	

Another Plan	• Services for which coverage is available:
	  • Under another plan, except for Eligible Expenses payable as described under ***Coordination of Benefits***;
	  • 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.	

Smoking Cessation **Limited to $500 per calendar year and $1,000 per lifetime - includes coverage for drugs and related office visits.**	**75%** of eligible expenses after satisfying **$250** deductible**.** **At Office:** **$15** Primary Physician/ **$40** Specialist copay per visit then **100%** of eligible expenses.	Not Covered.
Temporomandibular Joint (TMJ) Services 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. 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 Benefits are provided for surgical treatment if: • 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.	**Same as** • ***Physician's Office Services – Sickness and Injury*** • ***Physician Fees*** • ***Hospital-Inpatient Stay*** • ***Surgery - Outpatient*** • ***Lab, X-ray and Diagnostics – Outpatient*** • ***Therapeutic Treatments - Outpatient*** limited to $5,000 per lifetime. Coverage is available for the evaluation and treatment of temporomandibular joint syndrome (TMJ), including surgery. **The following services are not covered:** • 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	Not Covered.

Benefits for surgical services include arthrocentesis, arthroscopy, arthoplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include FDA-approved TMJ implants only when all other treatment has failed. Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described under ***Hospital – Inpatient Stay*** and ***Physician Fees for Surgical and Medical Services***, respectively.	scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.	
Travel	**The following services are not covered:** ● 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 ***Travel and Lodging.*** Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.	
Types of Care	**The following services are not covered:** ● 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).	
Vision and Hearing	**The following services are not covered:** ● bone anchored hearing aids except when either of the following applies: ● for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a	**The following services are not covered:** ● purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices;

	wearable hearing aid; or ● 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 **The following services are covered:** ● Lasik Surgery **50%** of billed charges. Any combination of Network and Non~Network Benefits for Lasik Surgery are limited to, **$2,000** per lifetime. **Please refer to *Vision Care* section for a description of covered services for vision.**	● Eye exercise or vision therapy **The following services are covered:** ● Lasik Surgery **50%** of billed charges. Any combination of Network and Non~Network Benefits for Lasik Surgery are limited to, **$2,000** per lifetime. **Please refer to *Vision Care* section for a description of covered services for vision.**
Wisdom Teeth	Not Covered.	Not Covered.
All Other Exclusions	**The following services are not covered:** ● Autopsies and other coroner services and transportation services for a corpse; ● Charges for: ● 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: ● 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: ● 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; ● 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: ● 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.

<!--section=Prescription_Drugs-->

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in your medical policy. If there is a difference between this summary and your policy, the terms of your policy will apply.

Providers, this summary is for members, to review the terms of your participation agreement, please visit unitedhealthcareonline.com

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)	**OptumRx** For all pharmacy support, please refer to the telephone number on the back of your ID card.	
Prescription Drug Definition 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-	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. Benefits for Prescription Drugs are available when the Prescription Drug meets the definition of a Covered Health Service.	

administration or administration by a non-skilled caregiver.		
Step Therapy	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. 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: ● A Covered Health Service as defined by the Plan; and ● Not Experimental and Investigational or Unproven.	Coverage up to **31**-day supply. ● **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.	Not Covered

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 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.	All oral and injectable diabetic medications, diabetic testing supplies, insulin needles, and syringes will be covered at a **$0** copay **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.	
Mail Order Purchases	Coverage up to **90**-day supply ● **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. **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
Health Care Reform Preventive Care Medications	Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined below. **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: • 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 screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. 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.
Specialty Pharmacy Program **Self- administered Diabetes products DO NOT fall into this category**	**Not Applicable – Has not opted into the Specialty Pharmacy Program**

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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
OptumRx **Refer to VCC Desktop for all telephone numbers.**	**Fresh Start Customer** **General Commercial Pharmacy Help Desk (Public Line)** 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) **Prior Authorization Department** **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. **OptumRx Mail Service Member Line** 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. **Specialty Pharmacy Patient Care Coordinator Line** ***Prescriber/Member New Prescription or New Services*** 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. **Specialty Pharmacy Patient Care Coordinator Line** ***Prescriber/Member Refill Prescription on Existing Services*** Member can contact this number to refill their specialty medication. Please be aware that this number is for REFILL only. **Doctor to Registered Pharmacist Line** 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. **BPL Number: 66046**
Pharmaceutical Products – Outpatient Quick Tip	**Specialty Medications** Member Services - Refer to the **Specialty Pharmacy SOP** for potential provider prior authorization requirements for drugs covered under the medical plan. Benefit information for Pharmaceutical Products can be located within several applicable areas. Please reference *Specialty Pharmacy* and *Drugs* for additional benefit and exclusion information.
Specialty Pharmacy Program Quick Tip	• The UnitedHealthcare Specialty Pharmacy Program applies to pharmacy benefits **only**. Reference the Customer Service drug list available on PharWeb *(access through customer service SOP)* 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. **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 ***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. • Hemophilia – will be addressed in ***Hemophilia Program*** section • HIV/Aids & Transplant *(exclusion will be for both classes if client has chosen this opt out)*

	• Oral Oncology Reference the Customer Service drug list available on PharWeb to verify specialty medications typically covered under medical benefits. **Clinical Coverage Review (CCR) team:** Follow standard clinical process for drug review with Medical Policy

<!--section=Other_Benefits-->

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Providers, this summary is for members, to review the terms of your participation agreement, please visit unitedhealthcareonline.com

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 questions call toll free at **1-877-818-5826.** TTY users dial **711**
hi HealthInnovations **™ Hearing Program**	Hearing loss is the third most common chronic condition among older Americans. It is under-diagnosed and treatment is usually expensive. More than **90%** of people with hearing loss can benefit from hearing aids, but do not use them because of the high cost. There is help! Through *hi HealthInnovations*™ and your medical plan. • There is **no cost** to use this program. • You can get high quality, custom-programmed hearing aids for a fraction of the cost for similar devices at other providers. • Your hearing aid is **programmed specifically for you**. • You pay only the discounted price for any hearing aid you buy. • Instead of thousands of dollars, the cost will range from **$599** to **$799** for each hearing aid, based on the hearing aid model you pick. • See the *Hearing Aid Description* below for more details.

Each hearing aid comes with:

- Free batteries and ear tubes/wax guards that will last most users six months.
- A 70-day no-risk trial period.
- A one-year manufacturer's warranty.

How to use your Plan Benefits

1. Ask your health care provider for a hearing test.
To determine if your medical plan pays for a hearing test, call the toll-free number on your ID card.

2. Send us your hearing test results.
If you have had a hearing test done within the past year or once you get a new hearing test, **fax your results** to **(877) 955-4336** or mail them to:

UnitedHealthcare
P.O. Box 356
Minneapolis, MN 55440

Please include your telephone number and answer these questions:
(a) *Have you worn hearing aids before?*
(b) *If you have worn hearing aids, what type of hearing aids?*
© *Have you worn ear molds before?*

3. Order from a selection of recommended hearing aids.
A week after submitting your test results, call us toll-free at **(866) 926-6632** from **9 a.m.** to **5 p.m.** Central Time, Monday through Friday. You will find out the type of hearing aids that have been recommended for you. At this time you can order your new hearing aid.

4. Use follow-up services if needed.
Your hearing aid comes with a 70-day money-back guarantee and free programming adjustments. Call toll-free at **(866) 926-6632** if you need assistance.

Customer Support Services
hi HealthInnovations™ offers several support services following your hearing aid purchase.

- Education and hearing rehabilitation services over the phone or online.
- Hearing health and new-user seminars on topics like effective communication strategies.
- Online captioned training videos about using, cleaning and maintaining your hearing aids.

To find a hearing professional or for help by phone, call us toll-free at **(866) 926-6632** from **9 a.m.** to **5 p.m.** Central Time, Monday through Friday.

	Hearing Aid Description *hi HealthInnovations*™ hearing aids use advanced technology to improve speech understanding and listening comfort. Each hearing aid is custom-programmed to your specific hearing needs. Every hearing test result and hearing aid order is reviewed by a licensed hearing professional to determine suitability. Hearing aid features include: • **Twelve** gain adjustment bands that are custom-programmed to your hearing needs. • Fully automatic digital algorithms that adapt to the user's environment. • Directional processing that enhances the amplification of the sounds in front of you while reducing distracting background noise from the side and behind. • Comfortable, stylish and discreet design. • Improves your ability to hear electronic devices such as a telephone and audio loops.
Incentives for Health	**NOT APPLICABLE**
Simply Engaged Wellness Incentive Program	**NOT APPLICABLE**
Vision Vendor	**NOT APPLICABLE**

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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.**	

<!--section=Mental_and_Nervous-->

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Providers, this summary is for members, to review the terms of your participation agreement, please visit unitedhealthcareonline.com

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** ● Call: **1-800-842-5724** **Employee Assistance Program (EAP)** Administered by: Optum ● Call: **1-800-842-5724**	Administered by: **United Behavioral Health –Health Plan Division** ● Call: **1-800-842-5724** **Employee Assistance Program (EAP)** Administered by: Optum ● Call: **1-800-842-5724**
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: ● diagnostic evaluations and assessment; ● treatment planning; ● referral services; ● medication management; ● individual, family, therapeutic group and provider-based case management services; and ● crisis intervention. Benefits include the following services provided on an inpatient basis: ● Partial	**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. **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.** **Network provider ONLY will be responsible for obtaining the following notification**	**Services received on an inpatient basis in a Hospital or Alternate Facility:** **Not Covered** **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 notification as described below. **When Benefits are provided for any of the services listed below, the following services require notification:** ● intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits

Hospitalization/Day Treatment; ● services at a Residential Treatment Facility; Benefits include the following services provided on an outpatient basis: ● Intensive Outpatient Treatment; 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. You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care. **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. 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. 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	**requirements:** ● 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 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). In addition, **Network provider** must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. ● 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	beyond **45-50** minutes in duration, with or without medication management. 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). In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. ● 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. If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to **50%** of Eligible Expenses

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.		
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following: ● 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. 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. Benefits include the following services provided on either an outpatient or inpatient basis: ● diagnostic evaluations and assessment; ● treatment planning; ● referral services;	**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. **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.** **Network provider ONLY will be responsible for obtaining the following notification requirements:** ● 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-	**Services received on an inpatient basis in a Hospital or Alternate Facility:** **Not Covered** **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 notification as described below. **When Benefits are provided for any of the services listed below, the following services require notification:** Neurobiological Disorders ~ Mental Health Services for Autism Spectrum Disorder ~ 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. For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the

• medication management; • individual, family, therapeutic group and provider-based case management services; and • crisis intervention Benefits include the following services provided on an inpatient basis: • Partial Hospitalization/ Day Treatment • services at a Residential Treatment Facility. Benefits include the following services provided on an outpatient basis: • Intensive Outpatient Treatment. 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. You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.	convulsive treatment; psychological testing; extended outpatient treatment visits beyond **45-50** minutes in duration, with or without medication management. 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). In addition, **Network provider** must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. • 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	admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. • 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. If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to **50%** of Eligible Expenses

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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

<!--section=Chemical_Dependency-->

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in your medical policy. If there is a difference between this summary and your policy, the terms of your policy will apply.

Providers, this summary is for members, to review the terms of your participation agreement, please visit unitedhealthcareonline.com

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** ● Call: **1-800-842-5724** **Employee Assistance Program (EAP)** Administered by: Optum ● Call: **1-800-842-5724**	Administered by: **United Behavioral Health-HealthPlan Division** ● Call: **1-800-842-5724** **Employee Assistance Program (EAP)** Administered by: Optum ● Call: **1-800-842-5724**
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: ● diagnostic evaluations and assessment; ● treatment planning; ● referral services; ● medication management; ● individual, family, therapeutic group and provider-based case management; ● crisis intervention. ● detoxification (sub-acute/non-medical);	**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. **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.** **Network provider ONLY will be responsible for obtaining**	**Services received on an inpatient basis in a Hospital or Alternate Facility:** **Not Covered.** **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 notification as described below. **When Benefits are provided for any of the services listed below, the following services require notification:** ● intensive outpatient program treatment; outpatient electro~convulsive treatment; psychological testing; extended outpatient treatment visits beyond **45-50** minutes in duration, with or without

Benefits include the following services provided on an inpatient basis: ● Partial Hospitalization/Day Treatment; ● services at a Residential Treatment Facility; Benefits include the following services provided on an outpatient basis: ● Intensive Outpatient Treatment; The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of carethe inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care. **Special Substance Use Disorder 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 Substance Use Disorder Services benefit. 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.	**the following notification requirements:** ● 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 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). In addition, **Network provider** must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. ● 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	medication management. 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). In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. ● 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. If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to **50%** of Eligible Expenses.

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.		

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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
Mental Health and Substance Use Disorder Services	Exclusions listed directly below apply to services described under ***Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders*** **and/or** ***Substance Use Disorders*** **The following services are not covered:** ● Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*; ● 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: ● 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

INFORMATION REGARDING
CONFLICT OF INTEREST QUESTIONNAIRE

During the 79th Legislative Session, House Bill 914 was signed into law effective September 1, 2015, which added Chapter 176 to the Texas Local Government Code. Recent changes have been made to Chapter 176 pursuant to HB23, which passed the 84th Legislative Session. Chapter 176 mandates the *public disclosure of certain information concerning persons doing business or seeking to do business with Collin County, including family, business, and financial relationships such persons may have with Collin County officers or employees involved in the planning, recommending, selecting and contracting of a vendor for this procurement.*

For a copy of Form CIQ and CIS:

http://www.ethics.state.tx.us/filinginfo/conflict_forms.htm

The vendor acknowledges by doing business or seeking to do business with Collin County that he/she has been notified of the requirements under Chapter 176 of the Texas Local Government Code and that he/she is solely responsible for complying with the terms and conditions therein. Furthermore, any individual or business entity seeking to do business with Collin County who does not comply with this practice may risk award consideration of any County contract.

For a listing of current Collin County Officers:
http://www.collincountytx.gov/government/Pages/officials.aspx

The following County employees will be involved in the planning, recommending, selecting, and contracting for the attached procurement:

Department:
Cynthia Jacobson - Human Resources Director
Lisa Meyer - Assistant Human Resources Director
Delena David – Senior Benefits Representative

Purchasing:
Michalyn Rains – CPPO, CPPB Purchasing Agent
Michelle Charnoski, CPPB – Assistant Purchasing Agent
Geri Osinaike – Senior Buyer

Commissioners' Court:
Keith Self – County Judge
Susan Fletcher – Commissioner Precinct No. 1
Cheryl Williams – Commissioner Precinct No. 2
Chris Hill – Commissioner Precinct No. 3
Duncan Webb – Commissioner Precinct No. 4

CONFLICT OF INTEREST QUESTIONNAIRE

FORM CIQ

For vendor doing business with local governmental entity

This questionnaire reflects changes made to the law by H.B. 23, 84th Leg., Regular Session.

This questionnaire is being filed in accordance with Chapter 176, Local Government Code, by a vendor who has a business relationship as defined by Section 176.001(1-a) with a local governmental entity and the vendor meets requirements under Section 176.006(a).

By law this questionnaire must be filed with the records administrator of the local governmental entity not later than the 7th business day after the date the vendor becomes aware of facts that require the statement to be filed. *See* Section 176.006(a-1), Local Government Code.

A vendor commits an offense if the vendor knowingly violates Section 176.006, Local Government Code. An offense under this section is a misdemeanor.

OFFICE USE ONLY

Date Received

1 **Name of vendor who has a business relationship with local governmental entity.**

2 ☐ **Check this box if you are filing an update to a previously filed questionnaire.** (The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than the 7th business day after the date on which you became aware that the originally filed questionnaire was incomplete or inaccurate.)

3 **Name of local government officer about whom the information is being disclosed.**

_____

Name of Officer

4 **Describe each employment or other business relationship with the local government officer, or a family member of the officer, as described by Section 176.003(a)(2)(A). Also describe any family relationship with the local government officer. Complete subparts A and B for each employment or business relationship described. Attach additional pages to this Form CIQ as necessary.**

A. Is the local government officer or a family member of the officer receiving or likely to receive taxable income, other than investment income, from the vendor?

☐ Yes ☐ No

B. Is the vendor receiving or likely to receive taxable income, other than investment income, from or at the direction of the local government officer or a family member of the officer AND the taxable income is not received from the local governmental entity?

☐ Yes ☐ No

5 **Describe each employment or business relationship that the vendor named in Section 1 maintains with a corporation or other business entity with respect to which the local government officer serves as an officer or director, or holds an ownership interest of one percent or more.**

6 ☐ Check this box if the vendor has given the local government officer or a family member of the officer one or more gifts as described in Section 176.003(a)(2)(B), excluding gifts described in Section 176.003(a-1).

7

_____ _____

Signature of vendor doing business with the governmental entity Date

CONFLICT OF INTEREST QUESTIONNAIRE
For vendor doing business with local governmental entity

A complete copy of Chapter 176 of the Local Government Code may be found at http://www.statutes.legis.state.tx.us/Docs/LG/htm/LG.176.htm. For easy reference, below are some of the sections cited on this form.

Local Government Code § 176.001(1-a): "Business relationship" means a connection between two or more parties based on commercial activity of one of the parties. The term does not include a connection based on:

(A) a transaction that is subject to rate or fee regulation by a federal, state, or local governmental entity or an agency of a federal, state, or local governmental entity;

(B) a transaction conducted at a price and subject to terms available to the public; or

(C) a purchase or lease of goods or services from a person that is chartered by a state or federal agency and that is subject to regular examination by, and reporting to, that agency.

Local Government Code § 176.003(a)(2)(A) and (B):

(a) A local government officer shall file a conflicts disclosure statement with respect to a vendor if:

***

(2) the vendor:

(A) has an employment or other business relationship with the local government officer or a family member of the officer that results in the officer or family member receiving taxable income, other than investment income, that exceeds $2,500 during the 12-month period preceding the date that the officer becomes aware that

(i) a contract between the local governmental entity and vendor has been executed; or

(ii) the local governmental entity is considering entering into a contract with the vendor;

(B) has given to the local government officer or a family member of the officer one or more gifts that have an aggregate value of more than $100 in the 12-month period preceding the date the officer becomes aware that:

(i) a contract between the local governmental entity and vendor has been executed; or

(ii) the local governmental entity is considering entering into a contract with the vendor.

Local Government Code § 176.006(a) and (a-1)

(a) A vendor shall file a completed conflict of interest questionnaire if the vendor has a business relationship with a local governmental entity and:

(1) has an employment or other business relationship with a local government officer of that local governmental entity, or a family member of the officer, described by Section 176.003(a)(2)(A);

(2) has given a local government officer of that local governmental entity, or a family member of the officer, one or more gifts with the aggregate value specified by Section 176.003(a)(2)(B), excluding any gift described by Section 176.003(a-1); or

(3) has a family relationship with a local government officer of that local governmental entity.

(a-1) The completed conflict of interest questionnaire must be filed with the appropriate records administrator not later than the seventh business day after the later of:

(1) the date that the vendor:

(A) begins discussions or negotiations to enter into a contract with the local governmental entity; or

(B) submits to the local governmental entity an application, response to a request for proposals or bids, correspondence, or another writing related to a potential contract with the local governmental entity; or

(2) the date the vendor becomes aware:

(A) of an employment or other business relationship with a local government officer, or a family member of the officer, described by Subsection (a);

(B) that the vendor has given one or more gifts described by Subsection (a); or

(C) of a family relationship with a local government officer.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person ▶** | **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.