UnitedHealthcare Choice Plus *Plan QAC*

Choice Plus plan gives you the freedom to see any Physician or other health care professional from our Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, UnitedHealthcare only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination℠ services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Choice Plus *Benefits Summary*

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage. Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law. Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. *Prior Notification is required for certain services.	**Annual Deductible:** $1,000 per Covered Person per calendar year, not to exceed $3,000 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $5,000 per Covered Person per calendar year, not to exceed $10,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** $5,000,000 Maximum Policy Benefit per Covered Person for combined Network and Non-Network Benefits.	**Annual Deductible:** $2,000 per Covered Person per calendar year, not to exceed $6,000 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $10,000 per Covered Person, per calendar year, not to exceed $20,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the COC. **Maximum Policy Benefit:** $5,000,000 Maximum Policy Benefit per Covered Person for combined Network and Non-Network Benefits.
1. Ambulance Services - Emergency only	Ground Transportation: 30% of Eligible Expenses Air Transportation: 30% of Eligible Expenses	Same as Network Benefit
2. Dental Services - Accident only	*30% of Eligible Expenses *Prior notification is required before follow-up treatment begins.	*Same as Network Benefit *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment Network and Non-Network Benefits for Durable Medical Equipment are limited to $2,500 per calendar year.	30% of Eligible Expenses	*50% of Eligible Expenses *Prior notification is required when the cost is more than $1,000.
4. Emergency Health Services	$100 per visit	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations Refractive eye examinations are limited to one every other calendar year from a Network Provider.	$35 per visit	50% of Eligible Expenses Eye Examinations for refractive errors are not covered.
6. Home Health Care Network and Non-Network benefits are limited to 100 visits per calendar year.	30% of Eligible Expenses	*50% of Eligible Expenses
7. Hospice Care Network and Non-Network Benefits are limited to 360 days during the entire period of time a Covered Person is covered under the Policy.	30% of Eligible Expenses	*50% of Eligible Expenses
8. Hospital - Inpatient Stay	30% of Eligible Expenses	*50% of Eligible Expenses
9. Injections Received in a Physician's Office	$35 per visit	50% per injection
10. Maternity Services	Same as 8, 11, 12 and 13 No Copayment applies to Physician office visits for prenatal care after the first visit.	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	30% of Eligible Expenses	50% of Eligible Expenses
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment For mammography testing: No Copayment	50% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	30% of Eligible Expenses	50% of Eligible Expenses
Outpatient Therapeutic Treatments	30% of Eligible Expenses	50% of Eligible Expenses
12. Physician's Office Services	$35 per visit. No Copayment applies when a Physician charge is not assessed.	50% of Eligible Expenses. No Benefits for preventive care.
13. Professional Fees for Surgical and Medical Services	30% of Eligible Expenses	50% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to $2,500 per calendar year.	30% of Eligible Expenses	50% of Eligible Expenses
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
16. Rehabilitation Services - Outpatient Therapy Network and Non-Network Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	30% of Eligible Expenses	50% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	30% of Eligible Expenses	*50% of Eligible Expenses
18. Transplantation Services	*30% of Eligible Expenses	*50% of Eligible Expenses Benefits are limited to $30,000 per transplant.
19. Urgent Care Center Services	$50 per visit	50% of Eligible Expenses

Additional Benefits

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
Acupuncture Network and Non-Network Benefits are limited to 10 visits per calendar year.	Same as Phyisician's Office Services	Same as Phyisician's Office Services
Dental Services - Inpatient	*30% of Eligible Expenses	*50% of Eligible Expenses
Diabetes Treatment	Same Covered Health Services as for other medical conditions.	Same Covered Health Services as for other medical conditions.
Infertility Services Network and Non-Network Benefits are limited to $2,000 lifetime benefit maximum.	30% of Eligible Expenses	50% of Eligible Expenses
Mastectomy Services	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Medical Foods	30% of Eligible Expenses	50% of Eligible Expenses
Mental Health and Substance Abuse Services - Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits are limited to 20 visits per calendar year.	50% of Eligible Expenses	50% of Eligible Expenses
Mental Health and Substance Abuse Services - Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Network and Non-Network Benefits limited to 20 days per calendar year.	30% of Eligible Expenses	50% of Eligible Expenses
Mental Health Services - Severe Mental Health Illness and Serious Emotional Disturbances Must receive prior authorization through the Mental/ Substance Abuse Designee.	Same Covered Health Services as for other medical conditions.	Same Covered Health Services as for other medical conditions.
Nicotine Use Benefit Network and Non-Network Benefits are limited to $200 lifetime benefit maximum.	Same as Physician's Office Services	Same as Physician's Office Services
Osteoporosis Services	Same as 8, 11, 12 and 13	Same as 8, 11, 12 and 13
Ostomy Services	30% of Eligible Expenses	50% of Eligible Expenses
Special Footwear Network and Non-Network Benefits are limited to $1,000 lifetime benefit maximum.	30% of Eligible Expenses	50% of Eligible Expenses
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 24 visits per calendar year.	30% of Eligible Expenses	50% of Eligible Expenses
Telemedicine Services	Same as 11 and 12	Same as 11 and 12
Temporomandibular Joint Disorder (TMJ) Services Network and Non-Network Benefits are limited to $2,500 during the entire period of time you are covered under the Policy	Same as 8, 11 and 13	Same as 8, 11 and 13

Except as may be specifically provided in Section 1 of the Certificate of Coverage (COC) or through a Rider to the Policy, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Dental care except as described in Section 1 of the COC under the headings Dental Services - Accident only and Dental Services - Inpatient Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following: extraction, restoration and replacement of teeth. Medical or surgical treatments of dental conditions. Services to improve dental clinical outcomes. Dental implants. Dental braces. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following: Transplant preparation. Initiation of immunosuppressives. The direct treatment of acute traumatic Injury, cancer or cleft palate. As described in Section 1 of the COC under the heading Dental Services - Inpatient. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications, except those needed to treat diabetes. Non-injectable medications given in a Physician's office except as required in an Emergency. Over the counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded except as set forth under Experimental or Investigational Services in Section 10 of the COC. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot; shoe orthotics.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, ostomy supplies, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the COC.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the COC.

I. Nutrition

Megavitamin and nutrition based therapy. Nutritional counseling for either individuals or groups, except as provided for the treatment of diabetes. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk, except as described in Section 1 of the COC under the heading Medical Foods.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.) Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the COC (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments. Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

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

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the COC. Any solid organ transplant that is performed as a treatment for cancer. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs. Transplant services that are not performed at a Designated Facility. Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the COC.

O. Travel

Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

Q. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the COC.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Policy, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Policy ends, including health services for medical conditions arising prior to the date your coverage under the Policy ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.

Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer, or as described in Section 1 of the COC under the heading Temporomandibular Joint Disorder Services. Orthognathic surgery and jaw alignment except as a treatment of obstructive sleep apnea.

Surgical treatment and non-surgical treatment of obesity (including morbid obesity).

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring. Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

R. Preexisting Conditions *(applies only to groups of 50 or less employees)*

Benefits for the treatment of a Preexisting Condition are excluded until the earlier of the following: the date you have had Continuous Creditable Coverage for 6 months. This exclusion does not apply to newborn children or newly adopted children. This exception for newborn and adopted children no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.

UnitedHealthcare

Pharmacy Management Program ***Plan 02V***

UnitedHealthcare's pharmacy management program provides clinical pharmacy services that promote choice, accessibility and value. The program offers a broad network of pharmacies (more than 56,000 nationwide) to provide convenient access to medications.

While most pharmacies participate in our network, you should check first. Call your pharmacist or visit our online pharmacy service at www.myuhc.com. The online service offers you home delivery of prescriptions, ability to view personal benefit coverage, access health and well being information, and even location of network retail neighborhood pharmacies by zip code.

Copayment per Prescription Order or Refill

Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. You are responsible for paying the lower of the applicable Copayment or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment or the Home Delivery Pharmacy's Prescription Drug Cost.

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

	Retail Network Pharmacy For up to a 31 day supply	**Home Delivery Network Pharmacy** For up to a 90 day supply	**Retail Non-Network Pharmacy** For up to a 31 day supply
Tier 1	$10	$25	$10
Tier 2	$35	$87.50	$35
Tier 3	$60	$150	$60

Other Important Cost Sharing Information

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

Annual Drug Deductible	No Annual Drug Deductible
Out-of-Pocket Drug Maximum	No Out-of-Pocket Drug Maximum

Exclusions

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

Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.

Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.

Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.

Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven.

Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

Any product dispensed for the purpose of appetite suppression and other weight loss products.

A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

Unit dose packaging of Prescription Drug Products.

Medications used for cosmetic purposes.

Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.

Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

Prescription Drug Products when prescribed to treat infertility.

Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.

Prescription Drug Products for smoking cessation.

Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.

New Prescription Drug Products and/or new dosage forms until the date they are reviewed by our Prescription Drug List Management Committee.

Growth hormone therapy for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

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