UnitedHealthcare
HSA Choice Plus *Plan HDP*

With this HSA Choice Plus high-deductible health plan coverage, you have the option to open a Health Savings Account (HSA). An HSA is a financial account that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the Internal Revenue Service. The account acts like a regular checking account with a debit card and accrues interest. All money in the account is owned by you and is fully vested as soon as it is deposited. Funds can accumulate over time and the account is portable among employers. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

Under the HSA Choice Plus high-deductible medical plan, your annual deductible and out of pocket maximum includes both medical expenses and pharmacy expenses. All expenses are your responsibility until the deductible is reached. HSA 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^{SM} 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.

HSA 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.	**Combined Medical and Drug Annual Deductible:** For single coverage, the Annual Deductible is $1,250 per Covered Person per calendar year. For family coverage, the Annual Deductible is $2,500 per calendar year for all Covered Persons in a family. No one in the family is eligible for benefits until the family deductible is satisfied. **Combined Medical and Drug Out-of-Pocket Maximum:** For single coverage, the Out-of-Pocket Maximum is $1,250 per Covered Person per calendar year. For family coverage, the Out-of-Pocket Maximum is $2,500 per calendar year for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. **Maximum Policy Benefit:** $5,000,000 Maximum Policy Benefit per Covered Person for combined Network and Non-Network Benefits.	**Combined Medical and Drug Annual Deductible:** For single coverage, the Annual Deductible is $2,500 per Covered Person per calendar year. For family coverage, the Annual Deductible is $5,000 per calendar year for all Covered Persons in a family. No one in the family is eligible for benefits until the family deductible is satisfied. **Combined Medical and Drug Out-of-Pocket Maximum:** For single coverage, the Out-of-Pocket Maximum is $5,000 per Covered Person per calendar year. For family coverage, the Out-of-Pocket Maximum is $10,000 per calendar year for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. **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: 0% of Eligible Expenses Air Transportation: 0% of Eligible Expenses	Same as Network Benefit
2. Dental Services - Accident only	*0% 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.	0% of Eligible Expenses	*20% of Eligible Expenses *Prior notification is required when the cost is more than $1,000.
4. Emergency Health Services	0% of Eligible Expenses	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.	0% of Eligible Expenses	20% of Eligible Expenses Eye Examinations for refractive errors are not covered.
6. Home Health Care Network and Non-Network Benefits are limited to 60 visits for skilled care services per calendar year.	0% of Eligible Expenses	*20% 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.	0% of Eligible Expenses	*20% of Eligible Expenses
8. Hospital - Inpatient Stay	0% of Eligible Expenses	*20% of Eligible Expenses
9. Injections Received in a Physician's Office	0% per injection	20% per injection
10. Maternity Services	Same as 8, 11, 12 and 13	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	0% of Eligible Expenses	20% of Eligible Expenses
Outpatient Diagnostic Services	For preventive diagnostic services: No Copayment For preventive mammography testing: No Copayment For sickness and injury related diagnostic services: 0% of Eligible Expenses	 No Benefits for preventive care. 20% of Eligible Expenses 20% of Eligible Expenses
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	0% of Eligible Expenses	20% of Eligible Expenses
Outpatient Therapeutic Treatments	0% of Eligible Expenses	20% of Eligible Expenses
12. Physician's Office Services	Preventive medical care: No Copayment Sickness & Injury: 0% of Eligible Expenses	 No Benefits for preventive care. 20% of Eligible Expenses
13. Professional Fees for Surgical and Medical Services	0% of Eligible Expenses	20% of Eligible Expenses
14. Prosthetic Devices Network and Non-Network Benefits for prosthetic devices are limited to $2,500 per calendar year.	0% of Eligible Expenses	20% of Eligible Expenses

Types of Coverage	Network Benefits / Copayment Amounts	Non-Network Benefits / Copayment Amounts
15. Reconstructive Procedures	Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
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.	0% of Eligible Expenses	20% of Eligible Expenses
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 60 days per calendar year.	0% of Eligible Expenses	*20% of Eligible Expenses
18. Transplantation Services	*0% of Eligible Expenses	*20% of Eligible Expenses Benefits are limited to $30,000 per transplant.
19. Urgent Care Center Services	0% of Eligible Expenses	20% of Eligible Expenses

Additional Benefits

Biologically Based Mental Illness Diagnosis and treatment of biologically based mental illness as defined in Section 10 when provided by or under the direction of a Physician.	Same as 8, 11, 12 and 13	*20% of Eligible Expenses
Cleft Lip and Cleft Palate Treatment	Same as 8, 11, 12 and 13	*20% of Eligible Expenses
Clinical Trials for Treatment Studies on Cancer	Same as 8, 11, 12 and 13	*20% of Eligible Expenses
Dental Services - Hospital and Alternate Facility Health Services Related to Dental Care	Same as 8, 11 and 13	*20% of Eligible Expenses
Diabetes Treatment	Same as 11, 12 and 13	*20% of Eligible Expenses
Early Intervention Services	Same as 8, 11, 12 and 13	*20% of Eligible Expenses
Hemophilia and Congenital Bleeding Disorder Services	Same as 8, 11, 12 and 13	*Same as Network
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.	0% of Eligible Expenses	20% 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 are limited to 30 days per calendar year.	0% of Eligible Expenses	20% of Eligible Expenses
Prostate and Colorectal Cancer Screenings	Same as 11, 12 and 13	20% 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.	0% of Eligible Expenses	20% of Eligible Expenses

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

Except as described in Section 1 of the COC under the headings Dental Services - Accidental Only, Dental Services - Hospital and Alternate Facility and Cleft Lip and Clepf Palate Treatment, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, 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. 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 or Unproven Services are excluded. 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. There are two exceptions to this exclusion: Services provided under Section 1: What's Covered--Benefits under the heading Clinical Trials for Treatment Studies on Cancer; No prescribed drug shall be excluded as Experimental, Investigational or Unproven on the basis that the drug has not been approved by the Food and Drug Administration (FDA) for the treatment of the specific condition for which the drug has been prescribed, provided that: 1) the drug has been approved by the FDA for at least one indication and 2) the drug has been recognized as safe and effective for the treatment of the specific condition in either of the following standard reference compendia: the American Hospital Formulary Service Drug Information or the United States Pharmacopoeia Dispensing Information; and Benefits for any drug approved by the FDA for use in the treatment of cancer pain are covered even if the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription in excess of the recommended dosage has ben prescribed for a patient with intractable cancer pain.

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. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

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. This includes, but is not limited to, coverage required by workers' compensation or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected. Health Services for the 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. 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), when the services are considered to be dental in nature.

Upper and lower jaw bone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint, 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 date you have had Continuous Creditable Coverage for twelve 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 iPlan HSA

*Pharmacy Management Program **Plan 0H9***

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.

Under this pharmacy coverage plan, a deductible and out-of-pocket maximum apply. Please refer to the medical plan documents for the annual deductible & out-of-pocket maximum amounts. The deductible and the out-of-pocket maximum include both medical and pharmacy expenses. This means that you will pay the full amount we have contracted with the pharmacy to charge for your prescriptions (not just your copayment), until you have satisfied the deductible. Once the deductible is satisfied, your prescriptions will be subject to the copayments listed below. If you reach the out-of-pocket maximum, you will not be required to pay a copayment.

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	$30	$75	$30
Tier 3	$50	$125	$50

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	See Medical Benefit Summary
Out-of-Pocket Drug Maximum	See Medical Benefit Summary

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).