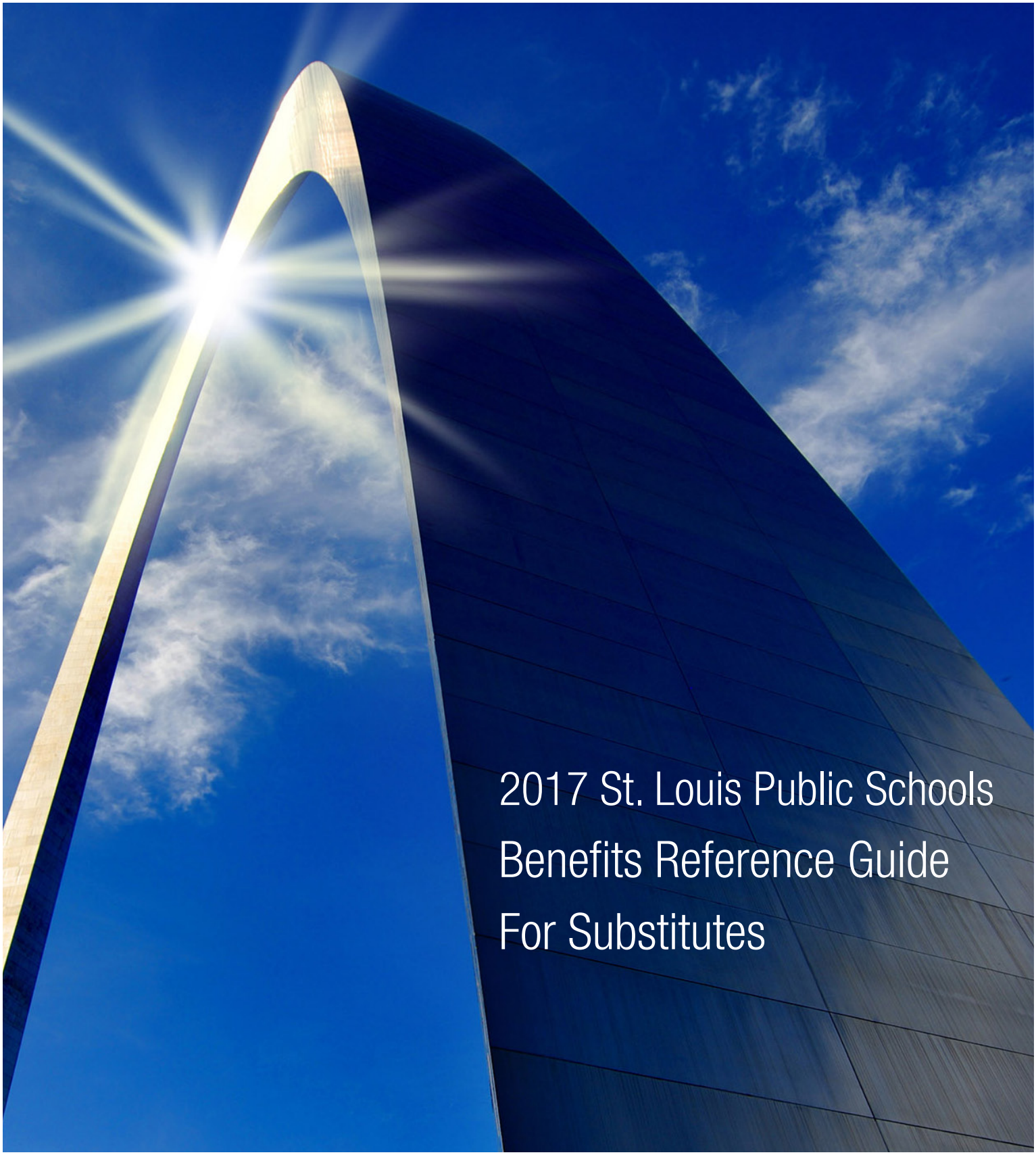


2017 St. Louis Public Schools Benefits Reference Guide For Substitutes

SAINT LOUIS
PUBLIC SCHOOLS

St. Louis Public Schools Benefits Overview

Welcome to the St. Louis Public Schools annual enrollment period for Calendar Year 2017. Annual enrollment will begin on **Sunday, October 23, 2016** and end at Midnight, CST on **Saturday, November 5, 2016**. You will be able to make corrections from **Sunday, November 13, 2016** through **Saturday, November 19, 2016**, Midnight, CST. Please use this 2017 enrollment guide, along with your enrollment worksheet, to make changes to medical, dental, and vision benefit options.

We encourage you to review the Enrollment Guide and your personal worksheet to determine your selections for 2017. If you do not make an election, a default enrollment will be made for you as described below.

What's New for 2017?

- Effective January 1, 2017, Medical coverage will be provided by UnitedHealthcare. All of your co-pays, deductibles and out-of-pocket amounts are the same as they were in 2016.
- Rates have increased slightly in most of the plans.
- Employees will receive new Medical and Pharmacy cards in the mail prior to January 1, 2017.

What you need to do

- Read the enclosed materials carefully to get answers to your questions.
- Discuss your options with your family. Make sure that you include any individuals who will be affected by your elections in the decision making process.
- **Enroll by the deadline, which is Midnight, CST November 5, 2016**. If you decide to change plans or delete/add eligible dependents, refer to the instructions in the Enrollment Guide. All eligible employees should enroll online at https://portal.adp.com. If you have questions or do not have access to a computer, call the Benefits Call Center at 1-866-345-SLPS (7577). Customer Care Representatives will be available to help you throughout the enrollment period and on an ongoing basis after the enrollment deadline.
- Finally, you will receive a personalized confirmation statement around the week of November 7th. If your confirmation does not reflect your elections for 2017, call the Benefits Call Center. You will not be allowed to make corrections after November 19, 2016, Midnight, CST.

What you need to remember

- Deductions for dependent coverage are taken from 24 paychecks for 12-month employees and 20 paychecks for non-12-month employees.
- Employee Assistance Services will be provided by Optum.
- Be sure to review your first paycheck in January 2017, to ensure that the correct amount has been deducted.
- Your medical and pharmacy information is combined on one card.
- You may select any combination of medical, dental, and/or vision plans, as well as any combination of coverage categories. The choice is up to you!
- Employees who are married to an employee of the St. Louis Public Schools **cannot** cover their spouse on any medical, dental, or vision plan. (Dual coverage is not allowed.)

Do not forget to make your benefit choices no later than Midnight, CST Saturday, November 5, 2016.

If you do not enroll

If you do not enroll by **November 5, 2016**, you will not be able to make changes to your benefits until the correction period or next open enrollment period - unless you have a change in status or experience another qualified event under which election changes are allowed. You will default to the coverages listed below.

Default Coverage for 2017

BENEFIT	COVERAGE LEVEL	PLAN
Medical and Prescription Drug Plan	Same as in 2016	UnitedHealthcare
Dental Plan	Same as in 2016	Same as 2016
Vision Plan	Same as in 2016	Same as 2016

Keep this guide for future reference.

St. Louis Public Schools

Important Dates to Remember

Your Open Enrollment Dates Are:
October 23, 2016 through November 5, 2016

Your Correction Dates are:
November 13, 2016 through November 19, 2016

Your period of coverage dates are:
January 1, 2017 through December 31, 2017

Welcome

The Board of Education of the City of St. Louis is committed to providing employees an affordable, high-quality employee benefits program while managing healthcare and vendor costs effectively.

It's time to enroll for your 2017 health and welfare benefits. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Annual enrollment is the one time during the year when you can make changes to your benefits (other than when you have a qualified family status change such as marriage, death, birth or adoption of a child, etc.). Don't miss this opportunity to review your benefit needs and the needs of your family. Review your current coverage; think about whether your needs have changed since you made those benefit decisions.

- Open enrollment will take place from Sunday, October 23 through Saturday, November 5, 2016 at Midnight, CST.
- Review this guide and your personal enrollment worksheet before you enroll for your benefits. If you have any questions, you may contact the Benefits Call Center phone line at 1-866-345-SLPS (7577) for more information.
- If you are enrolling online - the enrollment website will be available **24 hours a day throughout the enrollment period. To enroll, visit the enrollment website at https://portal.adp.com. New users will need the registration pass code: SLPS-ESS.**
- You can make changes online or call the Benefits Call Center at 1-866-345-SLPS (7577).

Table of Contents

Your 2017 Enrollment Materials

Your enrollment packet provides you with general and personalized information to help you make your 2017 elections, along with information on how to enroll online.

Your Packet Contains:

This enrollment guide - Provides an overview of your benefits for 2017, including details on each enrollment decision, information on how to enroll and where to find more information about your benefit options.

Your personal enrollment worksheet - Presents personalized benefits information such as your benefit options and associated premium costs.

Key Dates for Open Enrollment

You can make changes for benefits during the Open Enrollment period - October 23, 2016 through November 5, 2016, CST. If you don't enroll during this period, you will receive default benefits. (See "If You Do Not Enroll" on page 2 for more information.) You will be able to make changes or corrections from November 13, 2016 through November 19, 2016 at Midnight, CST.

The chart below provides more details about the coming weeks.

EVENT	TIMING	WHAT TO EXPECT
Open Enrollment	October 23 - November 5 at Midnight, CST	• Enrollment for Medical, Dental and Vision benefits for you and your dependents.
Confirmation statements arrive at your home	Week of November 7, 2016	• If your confirmation does not reflect your elections for 2017, call the Benefits Call Center phone line at 1-866-345-SLPS (7577).
Corrections	November 13 through November 19, 2016 at Midnight, CST	• Call before November 19, 2016, Midnight CST to correct any errors or discrepancies with your confirmation statement.
New benefit elections effective	January 1, 2017	• Your new benefits become effective.

How to Enroll

Prepare

Step 1: Read the Employee Benefits Enrollment Guide to learn about important changes to the benefits program for the new Plan Year. Review the benefits plan design and the costs for each benefit plan and consider changes that you want to make during Open Enrollment.

Step 2: Examine your personalized worksheet for current elections. Mark your choice for each plan on your worksheet.

Step 3: Have personal and dependent information available, such as Social Security numbers, birthdates, and bi-weekly amount that you want to contribute to a Flexible Spending Account (FSA) if you are participating.

Access Website

Step 1: Log onto https://portal.adp.com (new users refer to annual enrollment notification for instructions) and select the link "Enroll in 2017 Benefits."

Step 2: Click Continue to find instructions on each screen to guide you through the enrollment process.

Step 3: Complete the security screen before you enter your enrollment selections. You will need your Social Security number and your Personal Identification Number (PIN).

Enroll

Step 1: With your worksheet in hand, choose from the available options on each screen to obtain or complete benefits information.

Step 2: Review Personal Information and Current Dependents sections and update appropriately. Keep in mind that adding dependent information does not automatically enroll your dependents in any coverage. You must still select the plan option and coverage level to enroll your dependents.

Step 3: Continue to follow the instructions and steps to enter your choices for your 2017 benefits.

Confirm

Step 1: When you are finished, click on the Submit button to save your selections.

Step 2: Write down your confirmation number. You have the opportunity to receive an e-mail confirmation - just enter your e-mail address when prompted during the enrollment process.

Step 3: You may also print the Confirmation page to keep a copy for your records.

Step 4: During the week of November 7, 2016, you will receive a statement confirming your final benefits selections for 2017. To make corrections to your selections, simply go back to the website (https://portal.adp.com) as many times as you want beginning November 13 through November 19, 2016, Midnight, CST.

Step 5: If your confirmation does not reflect your elections for 2017, call the Benefits Call Center, 1-866-345-SLPS (7577), Monday through Friday, 8:00 a.m. to 6:00 p.m. CST.

Step 6: To log off, press Continue at the bottom of the page.

Eligibility

Who is Eligible

You can participate in the SLPS Benefits Plan if you are an eligible employee. The district defines an eligible employee as a full-time permanent employee with a scheduled work week of 30 hours or more. Eligible dependents can participate in some of the benefit plans.

Your eligible dependents may include your:

- Legal spouse (unless legally separated);
- Dependent child until the end of the month in which he or she reaches age 26 (please see definition below);
- The term Child includes any of the following:
  - A natural child.
  - A stepchild.
  - A legally adopted child.
  - A child placed for adoption.
  - A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.
- To be eligible for coverage under the Policy, a Dependent must reside within the United States.
- The definition of Dependent is subject to the following conditions and limitations:
  - A Dependent includes any child listed above under 26 years of age.
  - A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

If you opt out of medical coverage for yourself or waive coverage for your dependents, you cannot enroll until the next annual enrollment period unless you have a qualified life event or change in status, as described below.

When Coverage Begins

For newly hired or newly eligible employees, coverage is effective the 1st of the month following your hire date or eligibility date.

When You Can Make Changes

In general, you can make changes to your benefits coverage during annual open enrollment. However, you can make changes during the year if you have a qualified life event or change in status. Any changes you make for yourself and your dependents must be consistent with and on account of your change in status. For example, you can enroll your newborn in medical coverage, but you cannot drop coverage for your spouse or change medical options because of the birth of your child.

Qualified life events and changes in status that permit coverage changes are:

- Employee gains a tax dependent, i.e., through birth, legal adoption or placement of a child for adoption
- Marriage
- Divorce, annulment or legal separation
- Dependent who reaches age 26 or no longer meets eligibility requirements
- Spouse gains or loses coverage due to gaining or losing employment/ eligibility with current employer
- Death of a spouse
- Death of a dependent child
- Spouse/dependent becomes Medicare/Medicaid eligible or ineligible
- Dependent loses coverage

Coverage Levels

If you choose to enroll in the Medical and/or Dental Plans, you can elect coverage for:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

For the Vision Plan, you can elect coverage for:

- Employee Only
- Employee + 1 Dependent
- Employee + 2 or More Dependents

For the Supplemental Life Insurance Plan, you can elect coverage for:

- Employee Only
- Spouse
- Children

For the Flexible Spending Accounts, you can elect either or both:

- Healthcare Reimbursement Account
- Dependent Care Reimbursement Account

Cost of Coverage

The District pays the cost for your coverage (employee only) in the Base Medical, Dental and Vision Plans. You pay the full cost for your spouse and dependent children and the difference in cost between Base and Buy-up plans on a pre-tax basis.

The District pays the cost of your coverage (employee only) for Basic Term Life Insurance which includes coverage for AD&D. You pay the cost for your Supplemental Life Insurance on an after-tax basis.

You pay the cost for the Flexible Spending Accounts on a pre-tax basis. See your personal enrollment worksheet for specific cost information.

Change in Status

Listing of Allowable/Non-allowable Changes

The Change in Status charts on the following pages list the changes that you may make to your current benefits if you have a qualified change in status event. ***Note:*** *The plan options for Medical cannot change from one plan to the other, regardless of CIS event.*

If you have a qualified life event, you must make your benefit changes within 30 days of the actual event using the Benefit website, **https://portal.adp.com**. You may also contact the Benefits Call Center at 1-866-345-SLPS (7577), from 8:00 a.m. to 6:00 p.m. CST, Monday through Friday.

Otherwise you cannot make changes until the next benefits enrollment period. Most coverage changes due to a qualified life event or change in status are effective on the event date, if submitted within 30 days of the event. Please refer to the next few pages for a list of allowable changes based on your qualifying event.

Birth or Adoption *(If your newborn has not been assigned a SSN, then please enter your SSN)*		
	Allowed	**Not Allowed**
Medical	Enroll Self Add Spouse Add Children	Drop Self Drop Spouse Drop Children
Dental and Vision	Add Spouse Add Children	Drop Spouse Drop Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	No Limitations - No EOI required	N/A
FSA (both Health and Dependent Care)	Enroll Increase Coverage	Drop Coverage Decrease Coverage
Spouse/Dependent Eligible Medicare/Medicaid/Other Group Coverage*		
	Allowed	**Not Allowed**
Medical	Drop Spouse Drop Children	Enroll or Drop Self Add Spouse Add Children
Dental and Vision	Drop Spouse Drop Children	Add Spouse Add Children
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
Healthcare FSA	Drop Coverage Decrease Coverage	Enroll Increase Coverage
Dependent Care FSA	No Changes Allowed	N/A

***ONLY APPLICABLE TO THE AFFECTED DEPENDENT**

Change in Status

Marriage		
	Allowed	**Not Allowed**
Medical	Enroll or Drop Self Add Spouse Add or Drop Children	Drop Spouse
Dental and Vision	Add Spouse Add or Drop Children	Drop Spouse
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended with exception of $20,000 guarantee with no pend	
Supplemental Life - Child(ren)	No Limitations - No EOI required	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A
Divorce/Annulment/Legal Separation		
	Allowed	**Not Allowed**
Medical	Enroll Self Drop Spouse Add or Drop Children	Drop Self Add Spouse
Dental and Vision	Drop Spouse Add or Drop Children	Add Spouse
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	Drop Only	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A

Change in Status

Spouse/Dependent Gain Employment		
	Allowed	**Not Allowed**
Medical	Drop Self Drop Spouse Drop Child	Enroll Self Add Spouse Add Children
Dental and Vision	Drop Spouse Drop Children	Add Spouse Add Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
Healthcare FSA	Drop Coverage Decrease Coverage	Enroll Increase Coverage
Dependent Care FSA	No Limitations	N/A
Spouse/Dependent Loses Employment		
	Allowed	**Not Allowed**
Medical	Enroll Self Add Spouse Add Child	Drop Self Drop Spouse Drop Children
Dental and Vision	Add Spouse Add or Drop Children	Drop Spouse Drop Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
Healthcare FSA	Enroll Self Increase Coverage	Drop Coverage Decrease Coverage
Dependent Care FSA	No Limitations	N/A

Change in Status

Death of Spouse		
	Allowed	**Not Allowed**
Medical	Enroll Self Drop Spouse Add Children	Drop Self Add Spouse Drop Children
Dental and Vision	Drop Spouse Add Children	Add Spouse Drop Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	Drop Only	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A
Death of Dependent		
	Allowed	**Not Allowed**
Medical	Drop Children	Enroll or Drop Self Add or Drop Spouse Add Children
Dental and Vision	Drop Children	Add or Drop Spouse Add Children
Supplemental Life - Employee	Late Entrant (No existing) – All levels pended and EOI required Existing coverage - Increased by one level, no EOI required Existing coverage – Increased by more than one level EOI required	N/A
Supplemental Life - Spouse	All new levels pended and EOI required	N/A
Supplemental Life - Child(ren)	All new levels pended and an EOI is required	N/A
FSA (both Health and Dependent Care)	Drop Coverage Decrease Coverage	Enroll Increase Coverage

Change in Status

Dependent Loss of Coverage (turns age 26)		
	Allowed	**Not Allowed**
Medical	Drop Children	Enroll or Drop Self Add or Drop Spouse Add Children
Dental and Vision	Drop Children	Add or Drop Spouse Add Children
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
FSA (both Health and Dependent Care)	No Limitations	N/A
Coverage and Cost changes to Dependent Care FSA		
	Allowed	**Not Allowed**
Medical	No Changes Allowed	N/A
Dental and Vision	No Changes Allowed	N/A
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
FSA - Healthcare	No Changes Allowed	N/A
FSA - Dependent Care	Drop Coverage Increase Coverage Decrease Coverage	N/A
Spouse/Dependent no longer Eligible Medicare/Medicaid/Other Group Coverage*		
	Allowed	**Not Allowed**
Medical	Add Spouse Add Children	Enroll or Drop Self Drop Spouse Drop Children
Dental and Vision	Add Spouse Add Children	Drop Spouse Drop Children
Supplemental Life - Employee	No Changes Allowed	N/A
Supplemental Life - Spouse	No Changes Allowed	N/A
Supplemental Life - Child(ren)	No Changes Allowed	N/A
FSA - Healthcare	Add Coverage Increase Coverage	Drop Coverage Decrease Coverage
FSA - Dependent Care	No Changes Allowed	N/A

***ONLY APPLICABLE TO THE AFFECTED DEPENDENT**

Medical Plans

Your health care options for 2017 will include a choice of the following:

- UnitedHealthcare Base Choice Plus Plan
- UnitedHealthcare Buy Up Choice Plus Plan
- Opt out of medical coverage

UnitedHealthcare insures and administers both medical plans.

If you choose to opt out of Medical coverage because you have coverage under another plan, you will receive a monthly credit. A credit of $50 per month will be paid to 12-month employees; non-12-month employees receive a $60 monthly credit. This amount will be included in the last paycheck of each month, as taxable wages.

Comparing Your Medical Plan Options

Both UnitedHealthcare Base and UnitedHealthcare Buy Up plans are known as Choice Plus plans. This gives members the ultimate freedom of choice when selecting providers. The following provides details on the differences between selecting an in-network provider vs. an out-of-network provider.

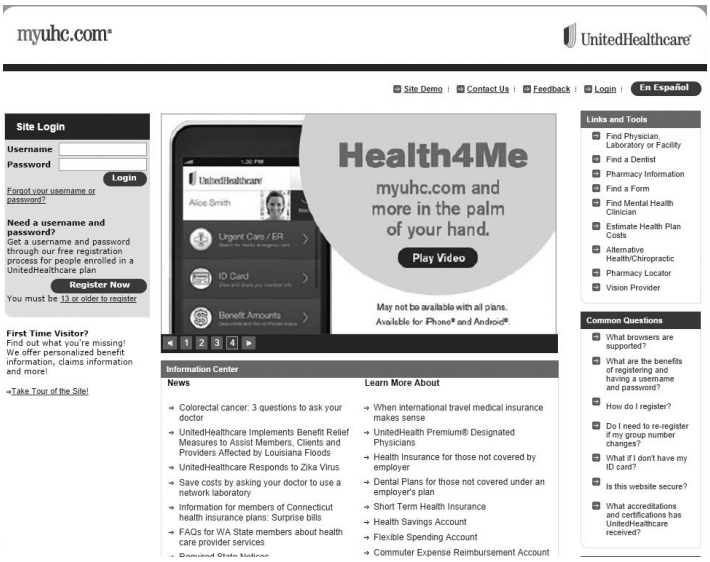
UnitedHealthcare Base Choice Plus Plan

This plan offers in- and out-of-network benefits, and you do not need to choose a primary care physician (PCP) or obtain a referral to see a network specialist. Your cost for care is lower when you use network providers. You can receive care from providers outside of the network, but your share of the cost is higher and you are responsible for paying any expenses that exceed the "Eligible Expense." (The "Eligible Expense" is a percentage of the published rates allowed by Medicare for the same or similar services.) You pay a set fee, or co-payment, for in-network physician office visits under this plan. When you use network providers, you often pay only a co-payment for covered services. Network services have lower deductibles and out-of-pocket costs. However, the co-payments and deductibles are higher for in-network benefits under this plan as compared to the UnitedHealthcare Buy Up Choice Plus Plan.

After you meet the annual deductible, the plan shares a percentage of covered medical expenses up to the "Eligible Expense" limits. Your share of the expenses is the coinsurance. For hospital stays, surgeries, extensive tests, lab tests and X-rays, you pay your annual deductible, the coinsurance and any separate hospital co-payments or confinement deductibles, if applicable. Once you reach the annual out-of-pocket maximum, the plan pays for certain covered expenses at 100% of "Eligible Expense" limits. Network care expenses are based on the contracted fees with that network provider.

UnitedHealthcare Buy Up Choice Plus

This plan works similar to the UnitedHealthcare Base Choice Plus plan. Under the UnitedHealthcare Buy Up Choice Plus plan, the co-payments and deductibles for in-network benefits are less.



Member website

- Get all your health plan information. In one place.
- **Make informed decisions.** As a member, **myuhc.com** gives you personalized plan information, care choices, budgeting tools and wellness tips – all in one spot. Download the UnitedHealthcare Health4Me® mobile app for on-the-go access.
- **Find and price the care you need.** The find-and-price care tool makes it simple to find a doctor, clinic, hospital, or lab based on location, specialty, reputation, cost of services, availability or hours of operation. You can even see patient ratings and compare quality and costs before you choose services.
- **Know your health care costs.** Get a clear picture of spending. View a snapshot of account activity, benefits received and outstanding balances. Track claims. Easily see the status of your claims.
- **Get and stay healthy.** Discover wellness tools and advice. Tailored to help you live healthier, and get the most from your plan.
- **Achieve your health goals.** Set goals and reach them with individualized recommendations on exercise, diet, therapy and more.
- **Join a healthy-living community.** Connect with other members for support and to share ideas on how to live balanced, healthy and active lives.

Plan Comparisons

The following chart compares your benefits under the UnitedHealthcare Base and UnitedHealthcare Buy Up plans.

Medical Plan				
	UnitedHealthcare Base Plan		UnitedHealthcare Buy Up Plan	
Deductible	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Individual	$500	$1,000	$200	$400
Family	$1,000	$2,000	$400	$800
Coinsurance (includes deductible)	80%	70%	90%	70%
Individual Out-of-Pocket Max	$3,500	$7,000	$1,400	$2,800
Family Out-of-Pocket Max	$7,000	$14,000	$2,800	$5,600
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Physician Office Visit				
Illness/Injury	$25/$35 Copay	70% AD	$15/$30 Copay	70% AD
Preventative Care	100%	70% AD	100%	70% AD
Hospital Services				
In-Patient	80% AD	70% AD	90% AD	70% AD
Out-Patient	80% AD	70% AD	90% AD	70% AD
Emergency Care				
Hospital Emergency Room	$250 Copay	$250 Copay	$150 Copay	$150 Copay
Urgent Care	$75 Copay	70% AD	$50 Copay	70% AD
Other Services				
Outpatient X-rays & Lab (except CT Scans, PET Scans, MRIs, and nuclear medicine)	100%	70% AD	100%	70% AD
Chiropractic Services	$20 Copay	70% AD	$20 Copay	70% AD
Physical Therapy	$25 Copay	70% AD	$15 Copay	70% AD
Durable Medical Equipment	80% AD	70% AD	90% AD	70% AD

VISION BENEFIT – under your UnitedHealthcare Base and Buy Up Choice Plus plans

- Routine vision exam every year (including refraction) at your physician office visit co-pay.
- Services must be performed at a Spectera Vision in-network provider, which consists of private practice and retail optical providers.

How to Receive Plan Benefits

Each time you need medical care, you decide the level of benefits by choosing in- or out-of-network providers. If you want in-network benefits, be sure to confirm that your provider is part of the UnitedHealthcare Choice Plus network before you receive care. If your provider is not part of the network, ask if he or she would be willing to join.

To choose a network provider, visit the UnitedHealthcare website at myuhc.com and click on *Find Physician, Laboratory or Facility* at the top of the page.

When you use an in-network provider, you do not have to file a claim - your provider files a claim directly with UnitedHealthcare. Depending on the type of service you receive, you will pay a co-payment amount or coinsurance and the plan pays the remaining covered amount. When you use an out-of-network provider, you may have to pay the full cost to the provider and file a claim to be reimbursed for a percentage of the covered expenses for medically necessary services, after you meet your annual deductible.

UnitedHealthcare Base Choice Plus Plan

UnitedHealthcare Base 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*.

This Summary of Benefits summarizes your obligation towards the cost of certain covered services. Refer to your Certificate of Coverage (COC) for a detailed description of covered services and limitations or exclusions.

To receive In-Network benefits, all covered services, except for Emergency Health Services, must be performed or referred by a participating UnitedHealthcare Choice Plus provider or authorized in advance by the Plan.

All services must be medically necessary as a condition of coverage and not otherwise limited or excluded.

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.
- Transition of care services are available to help identify and prevent delays in care for those who might need specialized help.
- 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.

UnitedHealthcare Base Choice Plus Plan

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
1.	**Annual Deductible** Total amount a plan member is required to pay each calendar year before he or she is eligible for certain health services. The Annual Deductible need only be met once per plan member per calendar year.	Individual $500 Family $1,000	Individual $1,000 Family $2,000
2.	**Annual Out-of-Pocket Maximum** Medical and pharmacy copayments, annual deductibles, and coinsurance apply to the out-of-pocket maximum, need only be met once per plan member per calendar year.	Individual $3,500 Family $7,000	Individual $7,000 Family $14,000
3.	**Maximum Lifetime Benefit** Combined total of all benefits.	Unlimited	Unlimited
4.	**Physician Office Visit - Preventive Care** Services include routine health assessment, well-child care, child health supervision services, immunizations and injections, hearing test, annual self-referred gynecological examination and pap smear, and mammogram screening.	For Primary Care Services $0 Copay per visit For Specialty Care Services $0 Copay per visit	For Primary Care Services 30% Coinsurance per visit after Deductible For Specialty Care Services 30% Coinsurance per visit after Deductible
5.	**Physician Office Visit-Medical Services** Services include diagnosis, consultation and treatment, diagnostic tests and radiology services, surgery, vision examination and refraction, and allergy tests and treatment.	For Primary Care Services $25 Copay per visit For Specialty Care Services $35 Copay per visit	For Primary Care Services 30% Coinsurance per visit after Deductible For Specialty Care Services 30% Coinsurance per visit after Deductible
6.	**Chiropractic Services** Coverage is provided for chiropractic services up to 26 visits.	$20 Copay per visit	30% Coinsurance per visit after deductible
7.	**Emergency Room Services** Coverage is provided for worldwide emergency health services as defined in the COC.	$250 Copay per visit (waived if patient is admitted)	$250 Copay per visit (waived if patient is admitted)

UnitedHealthcare Base Choice Plus Plan

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
8.	**Emergency Ambulance Services** Coverage is provided for Emergencies as defined in the COC.	20% Coinsurance per occurrence after deductible	20% Coinsurance per occurrence after deductible
9.	**Urgent Care Services** Urgent care services at participating alternate facilities both in and out of the service area are covered.	$75 Copay per visit	30% Coinsurance per occurrence after deductible
10.	**Maternity Care Office Visits** Covered services include pre-natal and post-natal care, examinations, tests and educational services.	$25 Copay first visit only	30% Coinsurance first visit only after deductible
11.	**Maternity Care, Inpatient Hospital** Covered services include all physician services for mother and newborn(s), delivery, newborn nursery services and semi-private room.	20% Coinsurance per admission after deductible	30% Coinsurance per admission after deductible $1,000 penalty for failure to precertify
12.	**Outpatient Services and Diagnostic Procedures and Tests** Coverage includes diagnostic procedures and tests, including but not limited to lab and radiology. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the Outpatient for Surgery section.	0% Coinsurance per visit after deductible	30% Coinsurance per visit after deductible 20% penalty for failure to precertify

UnitedHealthcare Base Choice Plus Plan

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
13.	**High Technology Diagnostic Services, Tests, and Procedures** Including, but not limited to: MRI, MRA, CT Scans, Thallium Scans, Nuclear Stress Tests, PET Scans, Echocardiograms, Ultrasounds (regardless of where service is performed)	20% Coinsurance per visit after deductible	30% Coinsurance per visit after deductible 20% penalty for failure to precertify
14.	**Outpatient Surgery** Benefits are provided for covered services rendered at an outpatient hospital or free standing surgery center.	20% Coinsurance per visit after deductible	30% Coinsurance per visit after deductible 20% penalty for failure to precertify
15.	**Inpatient Hospital Services** Unlimited coverage is provided for medically necessary physician and surgeon services, semi-private rooms, operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term rehabilitation services, nursing care, meals and special diets.	20% Coinsurance per admission after deductible	30% Coinsurance per admission after deductible $1,000 penalty for failure to precertify
16.	**Skilled Nursing Facility** Coverage is provided in lieu of an inpatient hospital admission when approved by the Plan. Coverage is provided for a semi-private room.	20% Coinsurance per admission after deductible Limited to 45 days per calendar year	30% Coinsurance per admission after deductible Limited to 45 days per calendar year $1,000 penalty for failure to precertify
17.	**Home Health Care and Hospice** Coverage is provided when services are authorized in advance by the Plan.	20% Coinsurance per visit after deductible	30% Coinsurance per visit after deductible 20% penalty for failure to precertify
18.	**Durable Medical Equipment** Coverage is provided when services authorized in advance by the Plan.	20% Coinsurance of covered expenses after deductible	30% Coinsurance of covered expenses after deductible 20% penalty for failure to precertify

UnitedHealthcare Base Choice Plus Plan

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT-OF-NETWORK
19.	**Orthotics and Prosthetics** Coverage is provided when services authorized in advance by the Plan.	20% Coinsurance of covered expenses after deductible (covers initial placement only)	30% Coinsurance of covered expenses after deductible (covers initial placement only) 20% penalty for failure to precertify
20.	**Physical and Occupational Therapy** Coverage is provided for medically necessary outpatient physical, occupational and speech therapy when authorized in advance by the Plan. Limited to 60 combined visits.	$25 Copay per visit after deductible	30% Coinsurance per visit after deductible 20% penalty for failure to precertify
21.	**Mental Health/Substance Abuse - Inpatient** All mental health services must be prior authorized in advance by calling the UnitedHealthcare behavior health line toll free at 800-622-7276.	20% Coinsurance per admission after deductible	30% Coinsurance per admission after deductible $1,000 penalty for failure to precertify
22.	**Mental Health/Substance Abuse - Outpatient** All mental health services must be prior authorized in advance by calling the UnitedHealthcare behavior health line toll free at 800-622-7276.	$35 Copay per visit	30% Coinsurance per visit after deductible

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Choice Plus Plan GH9

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** PS1

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com or by calling 1-866-633-2446.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$500** Individual / **$1,000** Family Non-Network: **$1,000** Individual / **$2,000** Family Per calendar year. Copays, and services listed below as "No Charge" do not apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: **$3,500** Individual / **$7,000** Family Non-Network: **$7,000** Individual / **$14,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premium**, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see **myuhc.com** or call **1-866-633-2446**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-633-2446 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	30% co-ins after ded.	Virtual visits (Telehealth) – $20 copay per visit by a designated virtual network provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$35 copay per visit	30% co-ins after ded.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit	30% co-ins after ded.	Cost share applies for only manipulative (chiropractic) services and is unlimited per calendar year.
	Preventive care / screening / immunization	No Charge	30% co-ins after ded.	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% co-ins after ded.	Pre-authorization is required non-network for sleep studies or benefit reduces to 50% of eligible expenses.
	Imaging (CT / PET scans, MRIs)	20% co-ins after ded.	30% co-ins after ded.	Pre- authorization is required non-network or benefit reduces to 50% of eligible expenses.
If you need drugs to treat your illness or	Tier 1 – Your Lowest-Cost Option	Not Covered	Not Covered	No coverage for prescription drugs with UnitedHealthcare.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
condition	Tier 2 – Your Midrange-Cost Option	Not Covered	Not Covered	
	Tier 3 – Your Highest-Cost Option	Not Covered	Not Covered	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	20% co-ins after ded.	30% co-ins after ded.	None
If you need immediate medical attention	Emergency room services	$250 copay per visit	$250 copay per visit	None
	Emergency medical transportation	20% co-ins after ded.	*20% co-ins after ded.	*Network deductible applies
	Urgent care	$75 copay per visit	30% co-ins after ded.	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	20% co-ins after ded.	30% co-ins after ded.	None
If you have mental health, behavioral health, or substance abuse	Mental / Behavioral health outpatient services	$35 copay per visit	30% co-ins after ded.	Partial hospitalization/intensive outpatient treatment: 20% coinsurance after deductible. Pre-authorization is required non-network for certain services or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
needs	Mental / Behavioral health inpatient services	20% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder outpatient services	$35 copay per visit	30% co-ins after ded.	Partial hospitalization/intensive outpatient treatment: 20% coinsurance after deductible. Pre-authorization is required non-network for certain services or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder inpatient services	20% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Prenatal and postnatal care	No Charge	30% co-ins after ded.	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	20% co-ins after ded.	30% co-ins after ded.	Inpatient pre-authorization may apply.
If you need help recovering or have other special health needs	Home health care	20% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Rehabilitation services	$25 copay per outpatient visit	30% co-ins after ded.	Depending on the type of therapy, benefits may be limited. Pre-authorization required for physical, occupational and speech non-network or benefit reduces to 50% of eligible expenses.
	Habilitative services	$25 copay per outpatient visit	30% co-ins after ded.	Limits are combined with Rehabilitation Services limits listed above. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Skilled nursing care	20% co-ins after ded.	30% co-ins after ded.	Nursing limited to 45 days per calendar year. Inpatient rehabilitation services are limited to 60 days per calendar year. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	20% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network for DME over $1,000 or no coverage. Covers 1 per type of DME (including repair/replacement) every 5 years.
	Hospice service	20% co-ins after ded.	30% co-ins after ded.	Inpatient pre-authorization is required or benefit reduces to 50% of eligible expenses.
If your child needs dental or eye care	Eye exam	$25 copay per outpatient visit	30% co-ins after ded.	Limited to 1 exam every 12 months.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses (Adult/Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Routine eye care (Adult/Child)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Missouri Department of Insurance at 1-800-726-7390 or insurance.mo.gov.

Additionally, a consumer assistance program may help you file your appeal. Contact Health Help Missouri Department of Insurance at 1-800-726-7390 or insurance.mo.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.
Chinese (中文): **如果需要中文的帮助**，请拨打这个号码1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.* ----------

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Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Choice Plus Plan GH9

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: Employee & Family **Plan Type:** PS1

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,840
- **Patient pays** $1,700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$200
Total	**$1,700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $800
- **Patient pays** $4,600

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$200
Coinsurance	$0
Limits or exclusions	$4,200
Total	**$4,600**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-866-633-2446 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to chiropractic services or non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Autism Spectrum Disorders Treatment

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. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia, except as described under Dental Anesthesia and Facility Charges in Section 1 of the COC). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of cancer, cleft palate or diseases of the mouth and if Injury to the tooth was a serious Injury as described under Dental Services - Accident Only in Section 1 of the COC. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Services your plan does not cover (Exclusions)

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to items needed for the medically appropriate treatment of newborn children diagnosed with congenital defects or birth abnormalities (This exclusion does not apply to foot orthotics described for which coverage is described under Durable Medical Equipment in Section 1 of the COC). Cranial banding. This exclusion does not apply to items needed for the medically appropriate treatment of newborn children diagnosed with congenital defects or birth abnormalities. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses (This exclusion does not apply to trusses described under Durable Medical Equipment in Section 1 of the COC) and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. This exclusion does not apply to assistive technology devices for children from birth to age three who are eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes (This exclusion does not apply to built-up shoes); shoe orthotics; shoe inserts and arch supports.

Services your plan does not cover (Exclusions)

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. This exclusion does not apply to Benefits described under Autism Spectrum Disorders treatment in section 1 of the COC consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions identified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to enteral formulas for Covered Persons under the age 6, for which Benefits are provided as described under Enteral Formulas and Low Protein Modified Food Products in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to enteral formulas for Covered Persons under age 6, for which Benefits are provided as described under Enteral Formulas and Low Protein Modified Food Products in Section 1 of the COC.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. This does not apply to Autism Spectrum Disorder. Outpatient cognitive rehabilitation therapy when not Medically Necessary for chronic or progressive conditions such as cerebral palsy, Alzheimer's disease or Parkinson's disease. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. 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, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of dislocation, tumors, cancer, obstructive sleep apnea or a Congenital Anomaly or Injury as described in the Reconstructive Procedures Benefit in Section 1 of the COC. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Services your plan does not cover (Exclusions)

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health Services and associated expenses for 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). This exclusion does not apply if the abortion procedure is necessary to preserve the life of the female upon whom the abortion is performed. Fetal reduction surgery. This exclusion does not apply if the abortion procedure is necessary to preserve the life of the female whom the abortion is performed.

Services Provided under Another Plan

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

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Types of Care

Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. This exclusion does not apply if you are eligible for and choose continuation coverage or if you are eligible for extended coverage for Total Disability. For more information refer to Section 4 of the COC. 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 a non-Network provider waives co-payments, co-insurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

UnitedHealthcare Buy Up Choice Plus Plan

UnitedHealthcare Buy Up 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*.

This Summary of Benefits summarizes your obligation towards the cost of certain covered services. Refer to your Certificate of Coverage (COC) for a detailed description of covered services and limitations or exclusions.

To receive In-Network benefits, all covered services, except for Emergency Health Services, must be performed or referred by a participating UnitedHealthcare Choice Plus provider or authorized in advance by the Plan.

All services must be medically necessary as a condition of coverage and not otherwise limited or excluded.

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.
- Transition of care services are available to help identify and prevent delays in care for those who might need specialized help.
- 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.

UnitedHealthcare Buy Up Choice Plus Plan

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT OF-NETWORK
1.	**Annual Deductible** Total amount a plan member is required to pay each calendar year before he or she is eligible for certain health services. The Annual Deductible need only be met once per plan member per calendar year.	Individual $200 Family $400	Individual $400 Family $800
2.	**Annual Out-of-Pocket Maximum** Medical and pharmacy copayments, annual deductibles, and coinsurance apply to the out-of-pocket maximum, need only be met once per plan member per calendar year.	Individual $1,400 Family $2,800	Individual $2,800 Family $5,600
3.	**Maximum Lifetime Benefit** Combined total of all benefits.	Unlimited	Unlimited
4.	**Physician Office Visit - Preventive Care** Services include routine health assessment, well-child care, child health supervision services, immunizations and injections, hearing test, annual self-referred gynecological examination and pap smear, and mammogram screening	For Primary Care Services $0 Copay per visit For Specialty Care Services $0 Copay per visit	For Primary Care Services 30% Coinsurance per visit after Deductible For Specialty Care Services 30% Coinsurance per visit after Deductible
5.	**Physician Office Visit - Medical Services** Services include diagnosis, consultation and treatment, diagnostic tests and radiology services, surgery, vision examination and refraction, and allergy tests and treatment.	For Primary Care Services $15 Copay per visit For Specialty Care Services $30 Copay per visit	For Primary Care Services 30% Coinsurance per visit after Deductible For Specialty Care Services 30% Coinsurance per visit after Deductible
6.	**Chiropractic Services** Coverage is provided for chiropractic services up to 26 visits.	$20 Copay per visit	30% Coinsurance per visit after deductible

UnitedHealthcare Buy Up Choice Plus Plan

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT OF-NETWORK
7.	**Emergency Room Services** Coverage is provided for worldwide emergency health services as defined in the COC.	$150 Copay per visit (waived if patient is admitted)	$150 Copay per visit (waived if patient is admitted)
8.	**Emergency Ambulance Services** Coverage is provided for Emergencies as defined in the COC.	10% Coinsurance per occurrence after deductible	10% Coinsurance per occurrence after deductible
9.	**Urgent Care Services** Urgent care services at participating alternate facilities both in and out of the service area are covered when authorized in advance by the plan.	$50 Copay per visit	30% Coinsurance per occurrence after deductible
10.	**Maternity Care Office Visits** Covered services include pre-natal and post-natal care, examinations, tests and educational services.	$15 Copay first visit only	30% Coinsurance first visit only after deductible
11.	**Maternity Care, Inpatient Hospital** Covered services include all physician services for mother and newborn(s), delivery, newborn nursery services and semi-private room.	10% Coinsurance per admission after deductible	30% Coinsurance per admission after deductible $1,000 penalty for failure to precertify
12.	**Outpatient Services and Diagnostic Procedures and Tests** Coverage includes diagnostic procedures and tests, including but not limited to lab and radiology. Certain procedures and tests are considered surgery, including but not limited to colonoscopy and endoscopy. Refer to the Outpatient Surgery section.	0% Coinsurance per visit after deductible	30% Coinsurance per visit after deductible 20% penalty for failure to precertify
13.	**High Technology Diagnostic Services, Tests, and Procedures** Including, but not limited to: MRI, MRA, CT Scans, Thallium Scans, Nuclear Stress Tests, PET Scans, Echocardiograms, Ultrasounds (regardless of where service is performed)	10% Coinsurance per visit after deductible	30% Coinsurance per visit after deductible 20% penalty for failure to precertify
14.	**Outpatient Surgery** Benefits are provided for covered services rendered at an outpatient hospital or free standing surgery center.	10% Coinsurance per visit after deductible	30% Coinsurance per visit after deductible 20% penalty for failure to precertify

UnitedHealthcare Buy Up Choice Plus Plan

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT OF-NETWORK
15.	**Inpatient Hospital Services** Unlimited coverage is provided for medically necessary physician and surgeon services, semi-private rooms, operating rooms and related facilities, intensive and coronary care units, laboratory, x-rays, radiology services and procedures, medications and biologicals, anesthesia, special duty nursing as prescribed, short-term rehabilitation services, nursing care, meals and special diets.	10% Coinsurance per admission after deductible	30% Coinsurance per admission after deductible $1,000 penalty for failure to precertify
16.	**Skilled Nursing Facility** Coverage is provided in lieu of an inpatient hospital admission when approved by the Plan. Coverage is provided for a semi-private room.	10% Coinsurance per admission after deductible Limited to 45 days per calendar year	30% Coinsurance per admission after deductible Limited to 45 days per calendar year $1,000 penalty for failure to precertify
17.	**Home Health Care and Hospice** Coverage is provided when services are authorized in advance by the Plan.	10% Coinsurance per occurrence after deductible	30% Coinsurance per visit after deductible 20% penalty for failure to precertify
18.	**Durable Medical Equipment** Coverage is provided when services authorized in advance by the Plan.	10% Coinsurance of covered expenses after deductible	30% Coinsurance of covered expenses after deductible 20% penalty for failure to precertify
19.	**Orthotics and Prosthetics** Coverage is provided when services authorized in advance by the Plan.	10% Coinsurance of covered expenses after deductible (covers initial placement only)	30% Coinsurance of covered expenses after deductible (covers initial placement only) 20% penalty for failure to precertify

UnitedHealthcare Buy Up Choice Plus Plan

	BENEFITS AND SERVICES	MEMBER RESPONSIBILITY	
		IN-NETWORK	OUT OF-NETWORK
20.	**Physical and Occupational Therapy** Coverage is provided for medically necessary outpatient physical, occupational and speech therapy when authorized in advance by the Plan. Limited to 60 combined visits.	$15 Copay per visit	30% Coinsurance per visit after deductible 20% penalty for failure to precertify
21.	**Mental Health/Substance Abuse -Inpatient** All mental health services must be prior authorized in advance by calling the UnitedHealthcare behavior health line toll free at 800-622-7276.	10% Coinsurance per admission after deductible	30% Coinsurance per admission after deductible $1 ,000 penalty for failure to precertify
22.	**Mental Health/Substance Abuse -Outpatient** All mental health services must be prior authorized in advance by calling the UnitedHealthcare behavior health line toll free at 800-622-7276.	$30 Copay per visit	30% Coinsurance per visit after deductible

UnitedHealthcare®

Choice Plus Plan GH8

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** PS1

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com or by calling 1-866-633-2446.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$200** Individual / **$400** Family Non-Network: **$400** Individual / **$800** Family Per calendar year. Copays, and services listed below as "No Charge" do not apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers
Is there an out-of-pocket limit on my expenses?	Network: **$1,400** Individual / **$2,800** Family Non-Network: **$2,800** Individual / **$5,600** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premium**, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers**, see myuhc.com or call **1-866-633-2446**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-866-633-2446 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	30% co-ins after ded.	Virtual visits (Telehealth) – $15 copay per visit by a designated virtual network provider. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$30 copay per visit	30% co-ins after ded.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$20 copay per visit	30% co-ins after ded.	Cost share applies for only manipulative (chiropractic) services and is unlimited per calendar year.
	Preventive care / screening / immunization	No Charge	30% co-ins after ded.	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% co-ins after ded.	Pre-authorization is required non-network for sleep studies or benefit reduces to 50% of eligible expenses.
	Imaging (CT / PET scans, MRIs)	10% co-ins after ded.	30% co-ins after ded.	Pre- authorization is required non-network or benefit reduces to 50% of eligible expenses.
If you need drugs to treat your illness or condition	Tier 1 – Your Lowest-Cost Option	Not Covered	Not Covered	No coverage for prescription drugs with United Healthcare.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Tier 2 – Your Midrange-Cost Option	Not Covered	Not Covered	
	Tier 3 – Your Highest-Cost Option	Not Covered	Not Covered	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	10% co-ins after ded.	30% co-ins after ded.	None
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay per visit	None
	Emergency medical transportation	10% co-ins after ded.	*10% co-ins after ded.	*Network deductible applies
	Urgent care	$50 copay per visit	30% co-ins after ded.	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Physician / surgeon fees	10% co-ins after ded.	30% co-ins after ded.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$30 copay per visit	30% co-ins after ded.	Partial hospitalization/intensive outpatient treatment: 10% coinsurance after deductible. Pre-authorization is required non-network for certain services or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
needs	Mental / Behavioral health inpatient services	20% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder outpatient services	$35 copay per visit	30% co-ins after ded.	Partial hospitalization/intensive outpatient treatment: 20% coinsurance after deductible. Pre-authorization is required non-network for certain services or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder inpatient services	20% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Prenatal and postnatal care	No Charge	30% co-ins after ded.	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	20% co-ins after ded.	30% co-ins after ded.	Inpatient pre-authorization may apply.
If you need help recovering or have other special health needs	Home health care	20% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Rehabilitation services	$25 copay per outpatient visit	30% co-ins after ded.	Depending on the type of therapy, benefits may be limited. Pre-authorization required for physical, occupational and speech non-network or benefit reduces to 50% of eligible expenses.
	Habilitative services	$25 copay per outpatient visit	30% co-ins after ded.	Limits are combined with Rehabilitation Services limits listed above. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Skilled nursing care	20% co-ins after ded.	30% co-ins after ded.	Nursing limited to 45 days per calendar year. Inpatient rehabilitation services are limited to 60 days per calendar year. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	20% co-ins after ded.	30% co-ins after ded.	Nursing limited to 45 days per calendar year. Inpatient rehabilitation services are limited to 60 days per calendar year. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Durable medical equipment	10% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network for DME over $1,000 or no coverage. Covers 1 per type of DME (including repair/replacement) every 5 years.
	Hospice service	10% co-ins after ded.	30% co-ins after ded.	Inpatient pre-authorization is required or benefit reduces to 50% of eligible expenses.
If your child needs dental or eye care	Eye exam	$15 copay per outpatient visit	30% co-ins after ded.	Limited to 1 exam every 12 months.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

• Acupuncture • Bariatric surgery • Cosmetic surgery	• Dental care (Adult/Child) • Glasses (Adult/Child) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S. •	• Private-duty nursing • Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

• Chiropractic care	• Hearing aids	• Routine eye care (Adult/Child)	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Missouri Department of Insurance at 1-800-726-7390 or insurance.mo.gov.

Additionally, a consumer assistance program may help you file your appeal. Contact Health Help Missouri Department of Insurance at 1-800-726-7390 or insurance.mo.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-633-2446.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.* ----------

UnitedHealthcare®

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Choice Plus Plan GH8

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: Employee & Family **Plan Type:** PS1

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,640
- **Patient pays** $900

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$200
Copays	$0
Coinsurance	$500
Limits or exclusions	$200
Total	**$900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $900
- **Patient pays** $4,500

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$100
Coinsurance	$0
Limits or exclusions	$4,200
Total	**$4,500**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-866-633-2446 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

Services your plan does not cover (Exclusions)

It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Alternative Treatments

Acupressure; acupuncture; aromatherapy; hypnotism; massage therapy; rolfing; art therapy, music therapy, dance therapy, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to chiropractic services or non-manipulative osteopathic care for which Benefits are provided as described in Section 1 of the COC.

Autism Spectrum Disorders Treatment

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. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia, except as described under Dental Anesthesia and Facility Charges in Section 1 of the COC). This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to: Transplant preparation; prior to initiation of immunosuppressive drugs; the direct treatment of cancer, cleft palate or diseases of the mouth and if Injury to the tooth was a serious Injury as described under Dental Services - Accident Only in Section 1 of the COC. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include: extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services - Accidental Only in Section 1 of the COC. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 1 of the COC. Dental braces (orthodontics). Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly.

Services your plan does not cover (Exclusions)

Devices, Appliances and Prosthetics

Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to items needed for the medically appropriate treatment of newborn children diagnosed with congenital defects or birth abnormalities (This exclusion does not apply to foot orthotics described for which coverage is described under Durable Medical Equipment in Section 1 of the COC). Cranial banding. This exclusion does not apply to items needed for the medically appropriate treatment of newborn children diagnosed with congenital defects or birth abnormalities. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses (This exclusion does not apply to trusses described under Durable Medical Equipment in Section 1 of the COC) and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophogeal voice devices for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC. This exclusion does not apply to assistive technology devices for children from birth to age three who are eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431. Oral appliances for snoring. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

Experimental, Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 1 of the COC. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Treatment of subluxation of the foot. Shoes (This exclusion does not apply to built-up shoes); shoe orthotics; shoe inserts and arch supports.

Services your plan does not cover (Exclusions)

Medical Supplies

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, gauze and dressings, urinary catheters. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 1 of the COC.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 1 of the COC.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 1 of the COC.

Tubing and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 1 of the COC.

Mental Health

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning. This exclusion does not apply to Benefits described under Autism Spectrum Disorders treatment in section 1 of the COC consistent with the requirements of Missouri State Section 376.1550 for those behavioral conditions identified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Nutrition

Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:

- Nutritional education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to enteral formulas for Covered Persons under the age 6, for which Benefits are provided as described under Enteral Formulas and Low Protein Modified Food Products in Section 1 of the COC. Infant formula and donor breast milk. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to enteral formulas for Covered Persons under age 6, for which Benefits are provided as described under Enteral Formulas and Low Protein Modified Food Products in Section 1 of the COC.

Personal Care, Comfort or Convenience

Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers; batteries and battery chargers; breast pumps (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement); car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment; home modifications such as elevators, handrails and ramps; hot tubs; humidifiers; Jacuzzis; mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; stair lifts and stair glides; strollers; safety equipment; treadmills; vehicle modifications such as van lifts; video players, whirlpools.

Services your plan does not cover (Exclusions)

Physical Appearance

Cosmetic Procedures. See the definition in Section 9 of the COC. Examples include: pharmacological regimens, nutritional procedures or treatments. Scar or tattoo removal or revision procedures (such as salabrasion and other such skin abrasion procedures). Skin abrasion procedures performed as a treatment for acne. Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. Treatment for skin wrinkles or any treatment to improve the appearance of the skin. Treatment for spider veins. Hair removal or replacement by any means. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 1 of the COC. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. This does not apply to Autism Spectrum Disorder. Outpatient cognitive rehabilitation therapy when not Medically Necessary for chronic or progressive conditions such as cerebral palsy, Alzheimer's disease or Parkinson's disease. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. 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, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of dislocation, tumors, cancer, obstructive sleep apnea or a Congenital Anomaly or Injury as described in the Reconstructive Procedures Benefit in Section 1 of the COC. Surgical and non-surgical treatment of obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 1 of the COC. In vitro fertilization regardless of the reason for treatment.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Services your plan does not cover (Exclusions)

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health Services and associated expenses for 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). This exclusion does not apply if the abortion procedure is necessary to preserve the life of the female upon whom the abortion is performed. Fetal reduction surgery. This exclusion does not apply if the abortion procedure is necessary to preserve the life of the female whom the abortion is performed.

Services Provided under Another Plan

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

Substance Use Disorders

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders. Gambling disorders. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in Section 1 of the COC and in the Schedule of Benefits.
- Not otherwise excluded in Section 2 of the COC.

Transplants

Health services for organ and tissue transplants, except those described under Transplantation Services in Section 1 of the COC. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.) Health services for transplants involving permanent mechanical or animal organs.

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 1 of the COC.

Services your plan does not cover (Exclusions)

Types of Care

Custodial care or maintenance care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care in Section 1 of the COC. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise or vision therapy. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery. Bone anchored hearing aids except when either of the following applies: For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 9 of the COC. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following: Medically Necessary; described as a Covered Health Service in Section 1 of the COC and Schedule of Benefits; and not otherwise excluded in Section 2 of the COC. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when: required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research (This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 1 of the COC); required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended. This exclusion does not apply if you are eligible for and choose continuation coverage or if you are eligible for extended coverage for Total Disability. For more information refer to Section 4 of the COC. 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 a non-Network provider waives co-payments, co-insurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the co-payments, co-insurance and/or deductible are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products. Autopsy. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

SLPS Wellness Program

In 2009, SLPS rolled out its first wellness plan in order to help our employees either stay healthy and/or become healthy. We are so impressed with the years of success and participation and want to continue the momentum into 2017 and beyond. We will partner with UnitedHealthcare for 2017 in order to deliver a comprehensive wellness plan to our district employees.

For the 2017 wellness plan year, you will need to complete a Biometric Screening or Health Survey in order to be considered a wellness participant and avoid being charged a non-participation fee.

Biometric Screening – this is a non-fasting finger prick blood draw which will test for Total Cholesterol, HDL, Ratio of Total Cholesterol to HDL, and Glucose.

Health Survey – a series of questions regarding your personal lifestyle and health.

The 2017 wellness plan will continue to include the following benefits:

1. **Digital online Missions** – services focus on losing weight, quitting smoking, exercising more, relieving stress, and more.
2. **Incentives/Rewards** – ability to earn gift cards for taking steps to understand and improve your health and well-being! See information in the box below. However, you have the right to waive participation in the gift card program.

Important Notes:

- Due to legal restrictions, UnitedHealthcare will not release any personal screening or assessment results to St. Louis Public Schools. Therefore, all personal and member-specific information is confidential.

Access the Reward Program Overview through Rally™ when you log in to myuhc.com for specific details regarding the wellness incentive program–SimplyEngaged®.

Earn a Reward:

- Participate in a biometric health screening and get a $75 reward
- Complete an online health survey through Rally when you log into myuhc.com within 90 days of the start of the program and get a $25 reward
- Get a $20 reward each month you visit a participating fitness center at least 12 times per month
- Complete a telephone-based health coaching program and get a $75 reward
- Complete at least 3 Missions through the Rally experience and get a $50 reward
- Estimate health care costs on myuhc.com and get a $25 reward

* Maximum reward per employee $200; Maximum reward per family $400. Each Employee and Spouse is eligible to receive a maximum of one reward for completing the wellness activity listed in each category. This includes a maximum of one reward per person for completing the Health Assessment.

† Children may not participate in the reward program.

UnitedHealthcare NurseLine and Care Options

With all of the options for getting care, this chart can help you understand which one is right for you and can help you save money.

Where to get care	What it is	Type of Care	Cost
NurseLine℠	NurseLine℠ connects you with registered nurses 24/7. Call 1-877-440-0547.	• Choosing appropriate medical care • Finding a doctor or hospital • Understanding treatment options • Achieving a healthier lifestyle • Answering medication questions	No additional cost
Virtual Visit	A virtual visit lets you see a doctor via your smartphone, tablet or computer.	• Allergies • Bladder infections • Bronchitis • Cough/colds • Diarrhea • Fever • Pink eye • Rashes • Seasonal flu • Sinus problems • Sore throats • Stomach aches	$
Convenience Care Clinics	Visit a convenience care clinic when you can't see your doctor and your health issue isn't urgent. These clinics are often in stores.	• Common infections (e.g. strep throat) • Minor skin conditions (e.g. poison ivy) • Vaccinations • Pregnancy tests • Minor injuries • Ear aches	$$
Primary Care Physician	Go to a doctor's office when you need preventive or routine care. Your primary doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	• Checkups • Preventive services • Minor skin conditions • Vaccinations • General health management	$$
Urgent Care	Urgent care is ideal for when you need care quickly, but it is not an emergency and your doctor isn't available. Urgent care centers treat issues that aren't life threatening.	• Sprains • Strains • Small cuts that may need a few stitches • Minor burns • Minor infections • Minor broken bones	$$$
Emergency Room	The ER is for life-threatening or very serious conditions that require immediate care. This is also when to call 911.	• Heavy bleeding • Large open wounds • Sudden change in vision • Chest pain • Sudden weakness or trouble talking • Major burns • Spinal injuries • Severe head injury • Breathy difficulty • Major broken bones	$$$$

Behavioral Health & Substance Abuse

Understanding Your Needs

UnitedHealthcare provides mental health and substance abuse services through United Behavioral Health ("UBH"). UnitedHealthcare and UBH work with you to help address behavioral health issues and improve your well-being.

UBH Case Managers help you receive the treatment you need.

They provide confidential support and treatment through a network of licensed and certified professionals, covering a variety of specialties to address your emotional wellness needs.

Getting Started

If you have questions concerning your behavioral health benefits and/or you would like to request services, please call the number below. This number can also be found on your UnitedHealthcare member ID card.

Experienced UBH personnel are available around the clock, and calls are kept confidential.

UBH providers offer a wide range of services, including, but not limited to:

- inpatient care
- outpatient therapy
- medication management
- alcohol or drug dependency programs
- intensive outpatient treatment

When You Call

You are connected with an experienced Behavioral Health Specialist who helps you decide the type(s) of service you need.

UBH will:

Provide you with all the information you need to schedule an appointment.

Ensure you receive the services you need to address your behavioral health concerns.

Behavioral Health Benefits

Your behavioral health benefit provides you with support for a wide range of concerns, such as:

- Managing stress
- Depression
- Eating disorders
- Coping with grief and loss
- Alcohol or drug dependency
- Anger management
- Anxiety
- Mental disorders
- Physical abuse
- Schizophrenia
- Mood disorders
- If you suffer from a behavioral health condition, UnitedHealthcare and UBH are here to help you get the treatment you need.

Physician Referral is NOT Required. Members or Providers can contact United Behavioral Health directly for a referral:

1-800-622-7276

Prescription Drug Benefits

The cost of prescription drugs is increasing rapidly - resulting in higher expenses for the District. Using your prescription drug benefit effectively by requesting generic drugs will help both you and the District manage expenses. The prescription drug program is self-funded by the District and currently administered by Express Scripts.

Prescription drugs are available to you for a co-payment that is dependent on the retail cost to the plan. This allows you and your physician to research the cost of various drugs that may be of benefit to you and determine the cost of the various drug options available to you.

The chart below compares your prescription drug benefits under the UnitedHealthcare Base and Buy Up plan options.

	Participants in UnitedHealthcare Choice Plus Base Plan	Participants in UnitedHealthcare Choice Plus Buy Up Plan
Prescription Drugs		
Co-pay at Participating Retail Pharmacies	$10* (drug cost of $10-$40) $25 (drug cost of $40.01-$80) $40 (drug cost of $80.01 & above)	$10* (drug cost of $10-$40) $20 (drug cost of $40.01-$80) $40 (drug cost of $80.01 & above)
Co-pay for Mail Service or selected pharmacies (up to a 90-day supply)	$20 (drug cost of $20-$80) $50 (drug cost of $80.01-$160) $80 (drug cost of $160.01 & above)	$20 (drug cost of $20-$80) $40 (drug cost of $80.01-$160) $80 (drug cost of $160.01 & above)

*If the actual cost of the drug is less than the co-pay, you pay actual cost.

Don't Forget!

The prescription drug plan will provide for a voluntary prescription drug savings program that allows members the option of replacing high cost brand drugs with over-the-counter (OTC) and generic alternatives.
The OTC program will cover over-the-counter equivalents of high cost and highly utilized drugs in the following three drug classes: PPIs (acid reducers, e.g. "Nexium"); NSAIDs (non steroidal anti-inflammatory drugs, e.g., "Celebrex"); and Antihistamines (e.g., brand drug Clarinex; OTC drug Claritin). The program will feature a zero ($0) co-pay for members able to use an OTC alternative with a physician's prescription.

Special Note:

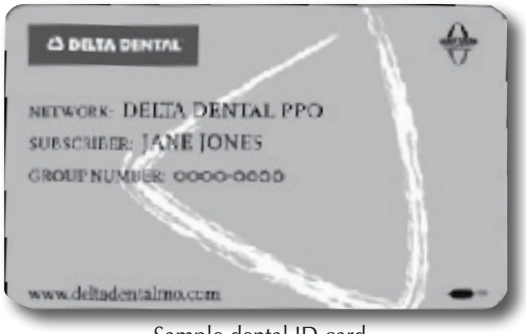
Retail 90-day supplies of maintenance medications can be filled at any in-network pharmacy location or by mail order via **www.express-scripts.com**. Click on "members"and register on the website. Once registered, follow the instructions to request prescriptions by mail.

The National Pharmacy network contains over 50,000 pharmacies which contain both chain pharmacies and independent pharmacies.

Examples of in-network Chain Pharmacies: Medicine Shoppe, Schnucks, Walgreen's, Wal-Mart, Target and K-Mart.

Pharmacy Locator services are available by contacting customer service at **1-877-850-3340** or by logging onto **www.express-scripts.com**. Once you have logged in, click "My Prescription Plan" and then click "Locate Pharmacy."

Dental Plan



Sample dental ID card

Delta Dental coverage helps you and your family with the cost of maintaining good dental health and treating dental disease or injury.

Your personal enrollment worksheet lists the options available to you, along with each option's cost per pay period.

	PPO	Premier	Out of Network
Deductible		Waived for Preventative & Ortho	
• Individual	$0	$100	$100
• Family	$0	$300	$300
Coinsurance			
• Preventative	100%	90%	70%
• Basic	80%	60%	50%
• Major	50%	40%	20%
Periodontics Covered Under		Basic	
Endodontics Covered Under		Basic	
Oral Surgery Covered Under		Basic	
Annual Maximum	$2,500	$1,500	$1,000
Orthodontia	50% to $1,000	50% to $1,000	50% to $1,000
Waiting Periods		None for Timely Entrants	
Out of Network UCR		Maximum Plan Allowance	
Dependent Age Limit		26	

PPO Network Dentists	Accept lower fee allowances and do not bill the patient for amounts over the PPO fee allowance - your out-of-pocket costs may be less.
	Will not bill patients for certain services that are considered a component of a standard procedure- saving you money.
	Under contract to file claims for Delta Dental patients - saving you time.
	Will only charge for deductibles, coinsurance and any non-covered services.
	Benefit payments are made directly to PPO network dentists.

Premier Network Dentists	Accept the Premier network contracted allowance and do not bill the patient for amounts over the contracted allowance - your out-of-pocket costs may be less.
	Will not bill patients for certain services that are considered a component of a standard procedure- saving you money.
	Under contract to file claims for Delta Dental patients- saving you time.
	Will only charge for deductibles, coinsurance and any non-covered services.
	Benefit payments are made directly to Premier network dentists.

Dentists not in a Delta Dental Network	Are reimbursed up to the allowed amount of what dentists charge in the same geographic area and with the same specialty.
	Bill the patient for ALL amounts not covered by the plan.
	Are not under contract to file claims for the patient.
	Benefit payments for non-network dentists are made to the member.

Vision Plan

The Vision Plan provides coverage for basic vision care services for you, and if applicable, your eligible family members. The plan is offered through Vision Benefits of America (VBA). You can search for VBA providers at **www.visionbenefits.com**.

Your personal enrollment worksheet lists your vision options and associated costs per pay period.

There is a new Buy Up option. If you choose this option, you will be locked into the benefit for three years; however, lenses and frames are available every 12 months.

Buy Up Plan	In-Network Provider	Out-of-Network Provider	
	You Pay	***You Pay***	***Plan will reimburse up to****
Examination	$10	100%	$36
• Lenses	$10		
• Single Vision		100%	$28
• Bifocal		100%	$45
• Trifocal		100%	$56
• Lenticular		100%	$80
• Polycarbonate (under age 19)		100%	$0
• Tinted (pink #1 or #2 only)		100%	$0
Frames	$10	100%	$45
Contact Lenses (evaluation and fitting)			
• Medically Necessary	Usual, Customary and Reasonable	100%	$210
• Elective	$130	100%	$130

* You will also pay a co-pay equal to the in-network co-pay amount.

Base Plan

Vision examinations are allowed once each 12 months.

New frames will be provided once each 24 months.

New lenses or contacts will be provided once each 24 months.

Base Plan elective contacts allowance of $105
In-Network Provider and Out-of-Network Provider.

Buy Up Plan

Vision examinations are allowed once each 12 months.

New frames will be provided once each 12 months.

New lenses or contacts will be provided once each 12 months.

Special Note:
VBA is a voucher program. When you are ready to use this benefit, you will need to obtain a vision authorization by calling **1-800-432-4966** or by logging on to the Vision Benefits of America website at **www.visionbenefits.com**.

Providers that do not require an authorization voucher are noted on the Vision Benefits website.

Vision Plan -Board of Education City of St. Louis

VISION BENEFITS OF AMERICA (VBA) maintains a network of more than 15,000 Participating Optometrists, Ophthalmologists and Retail Locations nationwide to provide professional vision care for persons covered under this plan.

What are the benefits?

VISION EXAMINATION - A complete analysis of the eyes and related structures to determine the presence of any vision problems.

- SPECTACLE LENSES-Your program provides the finest quality lenses fabricated to VBA's exacting standards. A VBA Participating Provider will order the proper lenses and verify their accuracy when finished.
- FRAMES-VBA plans offer a wide selection of fully covered designer frames; however, if you choose a frame which costs more than the amount allowed by your plan, you will be responsible for any additional controlled charges.

-or-

- CONTACTS SELECTED IN LIEU OF GLASSES-When contact lenses are selected in lieu of glasses, your plan will provide a total allowance of up to $130.00 toward their cost. THIS IS IN LIEU OF ALL OTHER BENEFITS FOR THE BENEFIT PERIOD. YOU WILL NOT RECEIVE ANY ADDITIONAL MONIES FOR CONTACT LENSES AND/OR CONTACT LENS EXAM COSTS THAT ARE MORE THAN THE $130.00 ALLOWANCE.

MEDICALLY NECESSARY CONTACT LENSES-Contact lenses are fully covered on a UCR* basis when a VBA Participating Provider receives prior approval for one of the following services related to eye disease or injury:

a) Following cataract surgery
b) To correct extreme visual acuity problems not correctable with spectacle lenses
c) To correct for significant anisometropia
d) To correct for keratoconus

- LASIK - All VBA covered subscribers are eligible to receive a significant discount at hundreds of provider locations nationwide. For more information regarding this benefit, please call VBA's Customer Service at 1-800-432-4966/option 5.
- Usual, Customary, Reasonable as determined by VBA.

*See Extra Cost and Non-Covered items as outlined in Section VI.

How often are these services available? (from the last date of service)

EXAMINATION: Once every 12 months
LENSES: Once every 12 months
FRAMES: Once every 12 months
-or-
CONTACT LENSES (in lieu of all other benefits for the benefit period): Once every 12 months

How much do I pay?

When you choose to obtain services from a VBA Participating Provider, this plan covers the benefits described herein (examination, professional services, lenses and frames) at no expense to you, if the materials selected fall within your plan's allowance. A $10 copayment applies to the vision exam and a $10 copayment applies to the total cost of the lenses and/or frames selected through a VBA Participating Provider only. The copayment (s) do not apply to the contacts.

How do I use this plan?

Prior to receiving vision benefits, you can easily check your eligibility and find a VBA Provider near your area by doing one of the following:

- Call VBA at 1-800-432-4966/push "1" then "5" and a VBA service representative will answer all of your questions, including helping you find a provider who would accept VBA's paperless E-Claims system - where you do not need a paper benefit form.

-or-

- Visit VBA's website at www.visionbenefits.com and obtain the same information, including providers with their names emboldened if they accept VBA's E-Claims system. When making your paperless claims appointment, please let the office know that you would like to use the VBA E-Claims system.

-or-

- If you prefer to use VBA's paper benefit form, simply call the same number, or visit the same website, and follow the instructions to request the VBA benefit form, which will be mailed directly to your home, along with a printed list of all VBA providers in your area.

Option I

If You Select the VBA Benefit Form and use a VBA Participating Doctor:

1. Choose a VBA Participating Doctor from the printed roster and make an appointment for the eye examination.
2. You MUST present the benefit form to the VBA Participating Doctor on your first visit. Failure to do so will result in your being partially reimbursed according to the Non-Participating Provider Reimbursement Schedule. When the examination has been completed, the VBA Participating Doctor will have you sign the benefit form and pay the copayment(s), if applicable.
3. The VBA Participating Doctor will take care of all paperwork for payment. VBA will pay the Doctor for the services you received according to VBA's contractual agreement with the Doctor.

Option II

If You Choose to See an Optometrist, Ophthalmologist or Dispensing Optician Who Is Not A VBA Participating Provider:

1. Make an appointment and receive the necessary services from the provider. Pay the Provider his full fee and obtain an itemized receipt which must contain the following information:

Vision Plan -Board of Education City of St. Louis

a) Patient's name
b) Date services began
c) The services and/or materials the patient received
d) The type of lenses the patient received (single vision, bifocal, etc.)

2. Mail your VBA Benefit Form and itemized receipts to:
   VISION BENEFITS OF AMERICA
   300 Weyman Plaza, Suite 400
   Pittsburgh, PA 15236-1588
3. You will be reimbursed directly according to the following Reimbursement Schedule:

Non-participating provider reimbursement schedule

PROFESSIONAL FEES	
Vision Examination, up to	$ 36.00
OPHTHALMIC MATERIALS	(pair)
Single Vision Lenses, up to	$ 28.00
Bifocal Lenses, up to	45.00
Trifocal Lenses, up to	56.00
Lenticular Lenses, up to	80.00
One Year Scratch Protection	N/A
Polycarbonate Lens Material	N/A
Frames, up to	$ 45.00

-or-

CONTACT LENSES (In lieu of all other benefits for the benefit period. You will not receive any additional monies for contact lenses and/or contact lens exam costs that are over the allowance).

Elective (In Lieu of Glasses)	$ 130.00
Medically Necessary	210.00

THERE IS NO ASSURANCE THE NON-PARTICIPATING PROVIDER REIMBURSEMENT SCHEDULE WILL COVER THE ENTIRE COST OF THE EXAMINATION, GLASSES OR CONTACTS.

Option III

If You Choose to See A Non-Participating Provider For An Eye Exam and Have A VBA Participating Provider Fill Your Prescription:

1. After receiving an eye exam from the Doctor, pay the Doctor his exam fee. Obtain a receipt for the exam and the prescription for your lenses.
2. Call one of the VBA Participating Providers who has an asterisk beside their name (this means they are willing to fill another Doctor's prescription) and make an appointment to have your prescription filled/lenses made.
3. Take your VBA Benefit Form and your prescription to the VBA Participating Provider on your first visit. They will fit you with your new glasses and take care of any paperwork associated with the glasses. The Participating Provider will be paid by VBA for all covered services.
4. You will be paid directly for your eye exam according to the above Reimbursement Schedule. Simply submit the paid exam receipt to VBA and indicate your employer's name and the employee's ss#.

NOTE: If any problems arise with your glasses or contacts due to an inaccurate prescription written by a Non-Participating Provider, VBA and our Participating Provider assume no responsibility.

Who is eligible?

The employee, as well as his or her dependents (if dependent coverage is provided). Eligible dependents would include the spouse and dependent children. Please check with your employer for age limits.

What optional vision materials are available at controlled pricing under this plan?

EXTRA COST--This plan is designed to fully cover your visual needs rather than cosmetic lens & frame options. There will be controlled extra costs involved if you select any of the following:

a) Rimless frames
b) A frame that costs more than your plan's allowance
c) Elective contact lenses (in excess of your plan's allowance)
d) Progressive lenses (available starting at $45.00)
e) Polycarbonate lens material for adults (covered if under 19)
f) Photosensitive lenses (glass or plastic)
g) Tinted lenses
h) Coated lenses (except 1 yr scratch protection is included)

NOT COVERED ITEMS--There are no benefits for professional services or materials connected with:

a) Orthoptics or vision training, subnormal vision aids or non-prescription lenses.
b) Lenses and frames furnished under this program which are lost or broken. These will not be replaced unless you are eligible for frames or lenses at that time.
c) Medical or surgical treatment of the eyes.
d) Two pairs of glasses in lieu of bifocals.
e) Services or materials provided as a result of any Workers' Compensation Law or similar legislation.
f) Any eye examination required by an employer as a condition of employment; or any services or materials provided by any other vision care plan, or group benefit plan containing benefits for vision care.

IF YOU HAVE QUESTIONS ABOUT YOUR VISION CARE COVERAGE OR THE FILING OF YOUR CLAIM, PLEASE CONTACT THE CUSTOMER SERVICE DEPARTMENT AT 1-800-432-4966.

VBA#670 09/12

2017 Cost of Coverage

The District pays the cost for your coverage (employee only) in the Medical, Dental and Vision Plans. You pay the full cost for your spouse and dependent children on a pre-tax basis. All elections for dependent Medical, Dental and Vision coverage are made on a pre-tax basis by way of salary deductions. An employee may choose to opt out of medical coverage if the employee has coverage under another plan and will receive a monthly credit from the District. You pay the cost for your Supplemental Life Insurance on an after-tax basis. These elections are provided under the Premium Conversion Plan maintained by the Board of Education and are governed by Internal Revenue Code Section 125.

2017 Employee Benefits Plan Year

	Monthly Premium	12-Month Employee 24 Pay Period Deductions	10, 10.5, 11-Month Employee 20 Pay Period Deductions
UnitedHealthcare Choice Plus Base Plan			
Employee Only	**$643.01 (Paid by SLPS)**	**$321.51 (Paid by SLPS)**	**$385.81 (Paid by SLPS)**
Spouse	$546.56	$273.28	$327.94
Child(ren)	$315.08	$157.54	$189.05
Spouse & Child(ren)	$731.15	$365.58	$438.69
UnitedHealthcare Choice Plus Buy Up Plan			
Paid by SLPS (Same as Base)	**$643.01 (Paid by SLPS)**	**$321.51 (Paid by SLPS)**	**$385.81 (Paid by SLPS)**
Employee Only	$71.03	$35.52	$42.62
Spouse	$677.87	$338.94	$406.72
Child(ren)	$420.91	$210.46	$252.55
Spouse & Child(ren)	$882.45	$441.23	$529.47
Delta Dental			
Employee Only	**$26.38 (Paid by SLPS)**	**$13.19 (Paid by SLPS)**	**$15.83 (Paid by SLPS)**
Spouse	$27.67	$13.84	$16.60
Child(ren)	$40.80	$20.40	$24.48
Spouse & Child(ren)	$64.33	$32.17	$38.60
Vision Benefits of America Base Plan			
Employee Only	**$1.55 (Paid by SLPS)**	**$0.78 (Paid by SLPS)**	**$0.93 (Paid by SLPS)**
Employee + 1	$2.35	$1.18	$1.41
Employee + 2 or more	$4.00	$2.00	$2.40
Vision Benefits of America Buy Up Plan (mandatory 3 year enrollment)**			
	$1.55 (Paid by SLPS)	**$0.78 (Paid by SLPS)**	**$0.93 (Paid by SLPS)**
Employee Only	$2.45	$1.23	$1.47
Employee + 1	$8.20	$4.10	$4.92
Employee + 2 or more	$12.30	$6.15	$7.38

*** District will pay the same amount toward the Buy Up Plan as they pay for the Base Plan. Employee will pay the difference between the Base and Buy Up plan amount.**

**** District will pay the Base plan amount for employee only. The cost for the Vision Buy Up plan represents the additional costs only. Employees that enroll in the Vision Buy Up plan are obligated to stay in the plan for three (3) years.**

Notice: Medicare Part D Certificate of Creditable Coverage

Important Notice from the Board of Education of the City of St. Louis About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Board of Education about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare Drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **The Board of Education of the City of St. Louis has determined that the prescription drug coverage offered by Express Scripts is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Express Scripts coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current coverage offered by Board of Education of The City of St. Louis, be aware that you and your dependents may be able to get this coverage back, as long as you are an eligible active full time employee.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your coverage with The Board of Education of the City of St. Louis and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information: Human Resources Reception at 314-231-3720 for assistance with Medicare Prescription Drug Coverage information ONLY.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Board of Education of The City of St. Louis changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Employee Notices

continued from page 69...

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**,
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: 9/1/2016
Name of Entity/Sender: Board of Education of The City of St. Louis
Contact-Position/Office: Human Resources Reception for Medicare Prescription Drug Coverage ONLY
Address: 801 North 11th Street, St. Louis, MO 63101
Phone Number: (314) 231-3720

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Notice: HIPAA Special Enrollment Rights

If you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
To request special enrollment or obtain more information, contact the Benefits Call Center at 1-866-345-7577.

Notice: Women's Health & Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator.

Notice: Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

See the next two pages for more CHIP information.

Employee Notices

CHIP continued...

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2016. You should contact your State for further information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943
FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid
Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447
MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
MINNESOTA – Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633
NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

Employee Notices

CHIP continued...

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
WISCONSIN – Medicaid
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

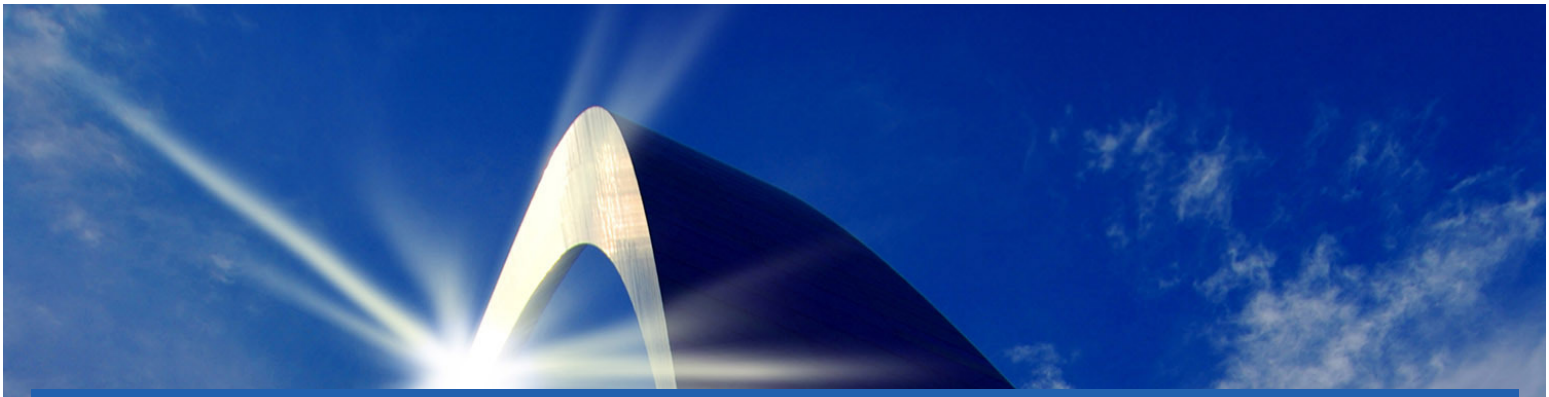
To see if any more States have added a premium assistance program since July 31, 2016 or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Notes



Contact Information

Benefits Call Center
1-866-345-7577
https://portal.adp.com

MEDICAL
UnitedHealthcare
1-844-298-8930
www.myuhc.com

PRESCRIPTION DRUGS
Express Scripts
1-877-850-3348
www.express-scripts.com

DENTAL
Delta Dental
1-800-335-8266
www.deltadentalmo.com

VISION
Vision Benefits of America
1-800-432-4966
www.visionbenefits.com

Employees can make changes online at **https://portal.adp.com** by selecting the link "Enroll in 2017 Benefits."
Employees may also contact the Benefits Call Center at 1-866-345-SLPS (7577).

Customer Service Representatives are available on a year-round basis, Mon - Fri, 8 a.m. - 6 p.m. CST.

Enroll Online at **https://portal.adp.com**

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.