CITY OF HIALEAH, FLORIDA
RISK MANAGEMENT DIVISION
MEMORANDUM

To: All Sworn Police Personnel

From: Robert Lloyd-Still, Risk Manager RLS

Date: October 31, 2011

Subject: Open Enrollment
COH Self-Funded Plan, HMO, Dental, GAP, AFLAC, Conseco

Arrangements for the open enrollment period have been finalized. This is the time when those currently enrolled in the City's various insurance programs, including the City's Self-Funded Plan, HMO, dental coverage through Humana, the GAP program through American Fidelity, or the other supplementary programs with AFLAC or Conseco, may make changes with their coverages. In regards to the HMO, AFSCME executed the contract with Coventry Healthcare to continue with the two options and the new rates.

The enrollment period will begin on Monday, November 14, 2011, and end on Wednesday, November 30, 2011 at 4:00 PM. Please note that the period to make insurance changes ends on Wednesday, November 30, 2011.

Anyone who desires to make a change must do so during the open enrollment, and you must remain within that plan until the next open enrollment scheduled by the City of Hialeah. Please see the attached schedule of benefits for the two different options being offered by Coventry Healthcare. Please see the attached summary sheet from United Healthcare that highlights the City's Self-Insured Plan. If you decide to add or remove dependents in the City's Self-Funded Plan, you may do so through the City's Risk Management Office located on the third floor of City Hall. All changes will become effective January 1, 2012.

Representatives from Coventry, Humana, American Fidelity, AFLAC, and CONSECO will be at City facilities at scheduled times to enroll new members, give out information and answer any questions. Please be sure to check with your supervisor before attending one of the meetings. The schedule is listed below:

November 14, 2011 through November 18, 2011 – (Each weekday) - City Hall (Employee Lounge) 11:00 AM - 3:00 PM.
November 21, 2011 through November 23, 2011 – (Monday, Tuesday, Wednesday) – Police Department (Training Bldg. Classroom #2) 7:30 AM - 9:30 AM, 1:00 PM – 3:30 PM
November 28, 2011 - Monday - Solid Waste Department (Shape-Up Room) 12:00 PM - 3:30 PM
November 29, 2011 - Tuesday - Recreation & Community Services Admin. (Conference Room) 1:30 PM - 4:30 PM
November 30, 2011 - Wednesday - Water & Sewer Department (Lunch Room) 12:30 PM - 3:30 PM

If you have any questions regarding any of the above information, please call the Risk Management Office at (305) 883-8059 or (305) 883-8048. A Coventry Health Plan representative can be reached at (888) 679-9148, between the hours of 8:30 am - 5:00 pm. Also, if you have questions concerning the dental coverage, you can speak with a Humana representative directly at (800) 342-5209.

Please visit the Risk Management Page of the City's website at www.hialeahfl.gov to view the Summary Plan Descriptions and other descriptions or updates regarding the City's different insurance programs. Also, open enrollment is an opportunity to update your beneficiary forms for the City's life insurance programs at Risk Management.

INSURANCE PREMIUMS
SWORN POLICE

Effective 1/01/12

CITY OF HIALEAH - SELF FUNDED PLAN:

	Monthly Premium	City's Contribution	Emp. Pays Monthly	Employee Pays Bi - Weekly
SINGLE	$342.15	$168.82	$173.33	$80.00
DOUBLE	$684.30	$458.97	$225.33	$104.00
FAMILY	$1,111.99	$864.99	$247.00	$114.00

Effective 1/11/2012
Coventry Health Care Of FL High Option

	Monthly Premium	City's Contribution	Emp. Pays Monthly	Employee Pays Bi - Weekly
SINGLE	$488.21	$235.80	$252.41	$116.50
DOUBLE	$892.29	$425.06	$467.23	$215.64
FAMILY	$1,265.92	$614.32	$651.60	$300.74

Effective 1/11/2012
Coventry Health Care Of FL Low Option

	Monthly Premium	City's Contribution	Emp. Pays Monthly	Employee Pays Bi - Weekly
SINGLE	$308.21	$235.80	$72.41	$33.42
DOUBLE	$647.23	$425.06	$222.17	$102.54
FAMILY	$748.32	$614.32	$134.00	$61.85

Effective 1/01/12

Humana (HMO Dental Coverage)

	Total Monthly Premium	Employee Pays Bi - Weekly
SINGLE	$14.44	$6.66
DOUBLE	$25.26	$11.66
FAMILY	$37.02	$17.09

Effective 1/01/12

Humana (PPO Dental Coverage)

	Total Monthly Premium	Employee Pay Bi - Weekly
SINGLE	$34.56	$15.95
DOUBLE	$67.38	$31.10
FAMILY	$120.04	$55.40

NOTE: Employer/Employee contributions for all plans and plan benefits are subject to change as a result of labor negotiations.

September 26th, 2011

Barbara Hernandez
President -AFSCME Local #161
City of Hialeah
501 PALM AVE
Hialeah Fl , 33010

RE: Renewal Notice for January 2012

Dear Mr$Hernandez:

On behalf of Coventry Health Care of Florida and the entire account services team I'd like to take this opportunity to thank you for allowing us to serve as your health benefits company over the past year. As the date of renewal for your company's Coventry Health Care of Florida Healthplan coverage approaches, I hope you will continue to depend on Coventry Health Care of Florida for your health benefit needs.

To assist you in the renewal process, enclosed with this letter you will find:

- Renewal rates
- Any large claims and pharmacy reports
- Summary of Benefits

If you accept the terms of the renewal, these documents will serve as an addendum to your current Group Master Contract. Coventry Health Care of Florida will renew your group insurance coverage for the next contract period upon our receipt of this letter signed by you. Your signature indicates your acceptance of the renewal contract. In order to ensure that there is no lapse in your company's Healthplan coverage, we must receive this letter no later than **September 27, 2011.**

As an employer, state law requires that you provide your employees with a 30-day Open Enrollment Period, prior to your group's contract renewal date. In order to maximize your company's Open Enrollment period, COVENTRY HEALTH CARE OF FLORIDA is happy to assist you in coordinating your Open Enrollment meetings. If you would like assistance please let me know.

Thank you again for selecting COVENTRY HEALTH CARE OF FLORIDA for your health benefit needs. We value your business and appreciate the opportunity to continue to serve you and your employees.

Sincerely,

Mercy Del Castillo

Mercy Del Castillo, Account Manager
(954) 375-1586/ E-fax# (877) 559-7716

Group Name: City of Hialeah | January 2012 Renewal

____ I accept the 2012 renewal		____ I reject the 2012 renewal
Barbara C. Hernandez		[signature]
Printed Name Barbara Hernandez		Signed Name & Date

References to Coventry Health Care of Florida include Coventry Health Plan of Florida, Inc., Coventry Health Care of Florida, Inc. and Coventry Health & Life Insurance Company.

HIGH OPTION

COVENTRY HEALTH CARE OF FLORIDA
RENEWAL RATES (HMO)

City of Hialeah

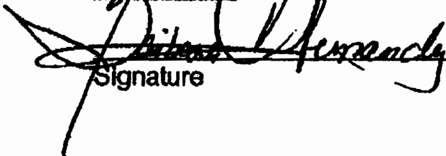
Super Group # 9875960000

The following rates are effective January 1st, 2012 through December 31st, 2012

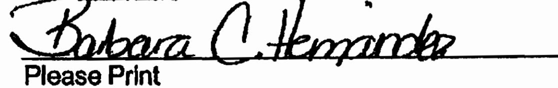
	Current Rates	Renewal Rates
Benefit Plan	City of Hialeah HMO OA EFDOA OPT 9 Hospital Deductible: $1,500 Hosp Admission : $200 copay per day for the first 5 days	City of Hialeah HMO OA EFDOA OPT 9 Hospital Deductible: $1,500 Hosp Admission : $200 copay per day for the first 5 days
Benefit Copays	PCP - $15 SPEC - $30 $15/$50/$70/20%	PCP - $15 SPEC - $30 $15/$50/$70/20%
Employee Only	$ 416.56	$ 488.21
Employee + 1	$ 761.34	$ 892.29
Employee + Fam	$ 1080.14	$ 1265.92
% above Current		17.2%

This quote is subject to the Health Plan's Underwriting Proposal Conditions and Provisions attached hereto. You must provide written acceptance to us AT LEAST 15 days prior to the effective date (notification period). Requests received after the notification period will be made effective the first of the month following receipt and the originally offered rates and benefits will be applicable during the interim period. In all cases, the original policy anniversary date remains unchanged.

_________ I accept the renewal proposal for HMO Plan _________ for the 2012 contract period.



Signature



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Coventry Health Care of Florida, Inc.

SCHEDULE OF BENEFITS
Enhanced Focused Deductible Open Access Plan EFDOA Option 9
City of Hialeah

Referrals are not required for Covered Services*

This Schedule of Benefits is not a complete summary or explanation of the Covered Services. Please review the Certificate of Coverage for an exact description of the Covered Services, limitations and exclusions and other terms and conditions of coverage.

Copayment Maximums (per calendar year)

Individual	$1,500
Family	$4,500

Annual Deductibles (per calendar year)

Hospital Deductible**	$1,500
Pharmacy Deductible	$0

Benefit Maximums (Coventry will pay)

Lifetime Maximum Individual Benefit	Unlimited
Pharmacy Maximum (per calendar year)	Unlimited, (copays are included in Lifetime Maximum Individual Benefit)

BENEFITS	MEMBER RESPONSIBILITY
Outpatient Physician Services	
Primary Care Physician Office Visits	$15 copay
Specialist Physician Office Visits	$30 copay

Office visit includes routine lab tests, diagnostic procedures and radiology, hearing and vision screening in physician's office, and outpatient surgery in the physician's office.

Wellness Care	No copay

(Wellness/Preventive care includes physical exams, eye exams, health education and counseling, immunizations, well-woman care, including Pap smears and well-child care to age 16 including immunizations.)

Well-child Care to age 16 including immunizations	No copay
Maternity Prenatal/ Postnatal Care	
• in a Physician's office	One-time $20 copay
• in a Sub-Specialty office	$20 copay
Non-Surgical Spine and Back Services Limitation: 20 visits per calendar year	Same as office visit copay
Second Medical and Surgical Opinion	
• by Participating Physician	Same as office visit copay
• by Non-Participating Physician	40% of Allowed Amount

Inpatient Hospital/Physician Services**

Service	Copay
Inpatient Hospital Facility Services	$200 copay per day for the first 5 days per admission

(Facility services include semi-private room & board, general nursing services, use of intensive care and specialty care units, x-rays, diagnostics/labs, operating and recovery rooms and prescription medications dispensed while confined.)

Service	Copay
Inpatient Rehabilitative Services Limitation: 30 days per calendar year	No additional copay
In-Hospital Maternity Care	No additional copay
Inpatient Neonatal Intensive Care Unit (NICU) (admission and subsequent inpatient care)	$200 copay per day for the first 5 days per admission
Inpatient Physician Services	Included in Hospital copay

(Physician Services include surgeon and assistant surgeon, anesthesiologist, specialists' consultations and other physician visits while confined.)

Outpatient Services

Service	Copay
Outpatient Diagnostic Services	
• at Hospital**	$60 copay
• at an Ambulatory Surgical Center	$20 copay
• at an Outpatient Diagnostic Center	$20 copay
• in a Physician's office	No additional copay
Outpatient Surgery (including physician and facility services)	
• at Hospital**	$200 copay
• at Ambulatory Surgical Center	$100 copay
• at an Outpatient Diagnostic Center	$20 copay
• in a Physician's office	No additional copay
Outpatient Endoscopic Procedures (Colonoscopy, Endoscopy, Sigmoidoscopy)	
• at Hospital**	$200 copay
• at Ambulatory Surgical Center	$100 copay
• at an Outpatient Diagnostic Center	$100 copay
• in a Physician's office	No additional copay
Outpatient Physical, Speech, and Occupational Therapy Limitation: 60 visits per calendar year, combined for all therapy types	
• at Hospital**	$20 copay
• at Freestanding Facility	$20 copay
Outpatient Cardiac and Respiratory Therapy	
• at Hospital**	$20 copay
• at Freestanding Facility	$20 copay
Outpatient Radiation and Chemotherapy	
• at Hospital**	$20 copay
• at Freestanding Facility	$20 copay
Routine Mammography (based on established guidelines)	No copay
Outpatient Dialysis	
• at Hospital**	$20 copay per treatment
• at Freestanding Facility	$20 copay per treatment

Skilled Nursing, Home Health and Hospice Care Services

Service	Copay
Skilled Nursing Care Limitation: 30 days per calendar year	$25 copay per day for the first 5 days per admission
Home Health Care Limitation: 60 visits per calendar year	No copay
Hospice Care Limitation: 210 days per lifetime	No copay

Emergency and Urgent Care Services

Service	Copay
Emergency Care at Hospital Emergency Room	$200 copay (waived if admitted)
Emergency Care at Urgent Care Facility	$20 copay
Emergency Care at Physician's Office	Same as office visit copay
Ambulance Service to Hospital	No copay

Mental Health, Alcohol & Substance Abuse Services

Service	Copay
Mental Health Care	
Inpatient Treatment**	Same as Inpatient Hospital Services
Outpatient Treatment	$20 copay
Alcohol and Substance Abuse Care	
Inpatient Detoxification**	$100 copay per day
Inpatient Rehabilitation Treatment**	Same as Inpatient Hospital Services
Outpatient Rehabilitation Treatment	$20 copay

Family Planning Services

Service	Copay
Voluntary Counseling	$20 copay
Infertility Diagnosis	$20 copay
Infertility Treatment	Not covered
Elective Abortion	Not covered
Elective Sterilization	
• at a Hospital**	$200 copay
• at a Freestanding Facility	$200 copay
Intrauterine Devices (IUD) (device, insertion, removal)	Same as office visit copay

Other Services

Service	Copay
Durable Medical Equipment	No copay
Breast Prosthetics	No copay
Other External Orthotic and Prosthetic Devices	No copay
Insulin (subject to Pharmacy Deductible)	Applicable copay per prescription
Diabetic Supplies (subject to Pharmacy Deductible) (Includes glucose monitors, test strips, lancets, etc.)	Applicable copay per month
Hearing Aids (other than Cochlear Implants)	Not covered

Circumcision

• In a Hospital prior to postnatal discharge**	No additional copay
• In a Physician's office	Same as office visit copay
• In a Hospital after postnatal discharge**	Same as outpatient surgery copay

Vision Care (following an operation for cataract or other diseases of the eye)
Limitation: initial prescription lenses (eye glasses or contact lenses)

• Frame and plastic single vision lenses	$29 copay
• Frame and plastic bifocal lenses (FT 25-35 or Executive lenses)	$49 copay
• Frame and plastic trifocal lenses (FT 25-35 or Executive lenses)	$59 copay
• Contact lenses	$69 copay

Other Provisions

Pre-Existing Conditions Exclusion	Late Enrollees

*PCP referrals are not required to obtain Covered Services however **certain Covered Services require Prior Authorization and approval by Coventry's Medical Management Program**. Please refer to the Certificate of Coverage for further details on Prior Authorization requirements.

**All services performed at a hospital (inpatient or outpatient) are subject to the Hospital Deductible. Services must be rendered within the Coventry network. Coventry participating physicians and providers have contracted with Coventry to provide care to our members.

This is a Schedule of Benefits only. Please refer to the Certificate of Coverage for complete details on the plan.

LOW OPTION

COVENTRY HEALTH CARE OF FLORIDA
RENEWAL RATES (HMO)

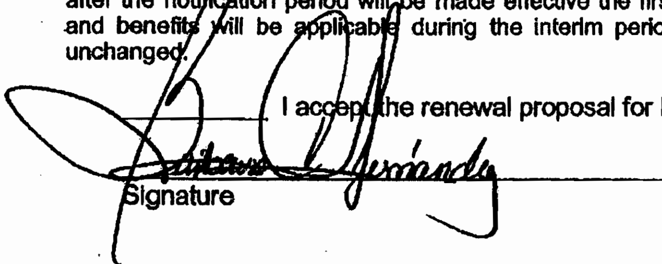
City of Hialeah

Super Group # 9875960000

The following rates are effective January 1st, 2012 through December 31st, 2012

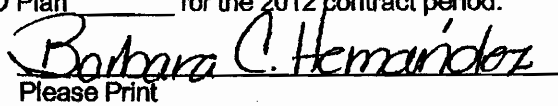
	Current Rates	Renewal Rates
Benefit Plan	City of Hialeah HMO OA FDCOA 3500 Hospital Deductible: $3,500 Hosp Admission : 30%	City of Hialeah HMO OA FDCOA 3500 Hospital Deductible: $3,500 Hosp Admission : 30%
Benefit Copays	PCP - $20 SPEC - $60 $20/$45/$70/20%	PCP - $20 SPEC - $60 $20/$45/$70/20%
Employee Only	$ 324.43	$ 308.21
Employee + 1	$ 681.29	$ 647.23
Employee + Fam	$ 787.70	$ 748.32
% above Current		-5.0%

This quote is subject to the Health Plan's Underwriting Proposal Conditions and Provisions attached hereto. You must provide written acceptance to us AT LEAST 15 days prior to the effective date (notification period). Requests received after the notification period will be made effective the first of the month following receipt and the originally offered rates and benefits will be applicable during the interim period. In all cases, the original policy anniversary date remains unchanged.



_________ I accept the renewal proposal for HMO Plan _______ for the 2012 contract period.

Signature



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Coventry Health Care of Florida, Inc.

SCHEDULE OF BENEFITS
HMO Large Group
Focused Deductible Coinsurance Open Access - $20/$60-$3,500 Plan

Referrals are not required for Covered Services*

This Schedule of Benefits is not a complete summary or explanation of the Covered Services. Please review the Certificate of Coverage for an exact description of the Covered Services, limitations and exclusions and other terms and conditions of coverage.

Out-of-Pocket, Copayment Maximums (per calendar year)

Individual	$4,500
Family 2 times the individual Out-of-Pocket amount	

Annual Deductibles (per calendar year)

Hospital Deductible*	
Individual	$3,500
Family	2 times the Individual Deductible
Pharmacy Deductible	Not applicable

Benefit Maximums (Coventry will pay)

Lifetime Maximum Individual Benefit	Unlimited
Pharmacy Maximum (per calendar year)	Unlimited

BENEFITS	MEMBER RESPONSIBILITY
Outpatient Physician Services	
Primary Care Physician Office Visits	$20 copay
Specialist Physician Office Visits	$60 copay

Office visit includes lab tests, X-rays, hearing and vision screening, outpatient surgery in the physician's office.

Adult Preventive Care	No copay

(includes annual physical exams, prostate cancer screening and colon cancer screening, eye exams, health education and counseling, immunizations, and annual well-woman exams, including Pap smears)

Child Preventive Care	No copay

(includes well child and well baby exams and immunizations)

Maternity Prenatal/ Postnatal Care	
• in a Physician's office	One-time $60 copay
• in a Sub-Specialty office	$60 copay
Non-Surgical Spine and Back Services Limitation: 20 visits per [calendar, contract] year	Same as office visit copay
Second Medical and Surgical Opinion	
• by Participating Physician	Same as office visit copay
• by Non-Participating Physician	40% of Allowed Amount

Inpatient Hospital/Physician Services*

Service	Cost
Inpatient Hospital Facility Services	30% coinsurance

(Facility services include semi-private room & board, general nursing services, use of intensive care and specialty care units, x-rays, diagnostics/labs, operating and recovery rooms and prescription medications dispensed while confined.)

Service	Cost
Inpatient Rehabilitative Services Limitation: 30 days per calendar year	30% coinsurance
In-Hospital Maternity Care	30% coinsurance
Inpatient Neonatal Intensive Care Unit (NICU)	30% coinsurance
Inpatient Physician Services	30% coinsurance

(Physician Services include surgeon and assistant surgeon, anesthesiologist, specialists' consultations and other physician visits while confined.)

Outpatient Services

Outpatient Diagnostic Services

Setting	Cost
• at a Hospital*	30% coinsurance
• at an Ambulatory Surgical Center	$150 copay
• at an Outpatient Diagnostic Center	$75 copay
• in a Physician's office	No additional copay

Outpatient Surgery (including physician and facility services)

Setting	Cost
• at a Hospital*	30% coinsurance
• at an Ambulatory Surgical Center	$300 copay
• at an Outpatient Diagnostic Center	$100 copay
• in a Physician's office	No additional copay

Outpatient Endoscopic Procedures (colonoscopy, endoscopy, sigmoidoscopy)

Setting	Cost
• at a Hospital*	30% coinsurance
• at an Ambulatory Surgical Center	$300 copay
• at an Outpatient Diagnostic Center	$300 copay
• in a Physician's office	No additional copay

Outpatient Physical, Speech, and Occupational Therapy
Limitation: 60 visits per calendar year, combined for all therapy types

Setting	Cost
• at a Hospital*	30% coinsurance
• at a Freestanding Facility	$60 copay

Outpatient Cardiac Therapy

Setting	Cost
• at a Hospital*	30% coinsurance
• at a Freestanding Facility	$60 copay

Outpatient Respiratory Therapy

Setting	Cost
• at a Hospital*	30% coinsurance
• at a Freestanding Facility	$60 copay

Outpatient Radiation and Chemotherapy

Setting	Cost
• at a Hospital*	30% coinsurance
• at a Freestanding Facility	$60 copay

Service	Cost
Routine Mammography (based on established guidelines)	No copay

Outpatient Dialysis

Setting	Cost
• at a Hospital*	30% coinsurance
• at a Freestanding Facility	$60 copay per treatment

Skilled Nursing, Home Health and Hospice Care Services

Service	Copay
Skilled Nursing Care Limitation: 30 days per calendar year	$100 copay per day for the first 1-5 days per admission
Home Health Care Limitation: 60 visits per calendar year	No copay
Hospice Care Limitation: 210 days per lifetime	No copay

Emergency and Urgent Care Services

Service	Copay
Emergency Care at Hospital Emergency Room	$300 copay (waived if admitted)
Ambulance Service to Hospital	No copay
Urgent Care Facility	$60 copay

Mental Health, Alcohol & Substance Abuse Services

Mental Health Care

Service	Copay
Inpatient Treatment*	Same as Inpatient Hospital Services
Outpatient Treatment	$60 copay

Alcohol & Substance Abuse Care

Service	Copay
Inpatient Detoxification*	Same as Inpatient Hospital services
Inpatient Rehabilitation Treatment*	Same as Inpatient Hospital services
Outpatient Rehabilitation Treatment	$60 copay

Family Planning Services

Service	Copay
Voluntary Counseling	$60 copay
Infertility Diagnosis	$60 copay
Infertility Treatment	Not covered
Elective Abortion	Not covered
Elective Sterilization	
• at a Hospital*	30% coinsurance
• at a Freestanding Facility	$300 copay
Intrauterine Devices (IUD) (device, insertion, removal)	Same as office visit copay

Other Services

Service	Copay
Durable Medical Equipment	$50 copay
Breast Prosthetics	$50 copay
Other External Orthotic and Prosthetic Devices	$50 copay
Insulin (subject to Pharmacy Deductible)	Applicable copay per prescription
Diabetic Supplies (subject to Pharmacy Deductible) (Includes glucose monitors, test strips, lancets, etc.)	Applicable copay per month
Hearing Aids (other than Cochlear Implants)	Not covered
Circumcision	
• In a Hospital prior to postnatal discharge	No additional copay
• In a Physician's office	Same as office visit copay
• In a Hospital after postnatal discharge	Same as outpatient surgery copay

Vision Care (following an operation for cataract or other diseases of the eye)
Limitation: initial prescription lenses (eye glasses or contact lenses)

Item	Copay
• Frame and plastic single vision lenses	$29 copay
• Frame and plastic bifocal lenses (FT 25-35 or Executive lenses)	$49 copay
• Frame and plastic trifocal lenses (FT 25-35 or Executive lenses)	$59 copay
• Contact lenses	$69 copay

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*All services performed at a hospital (inpatient or outpatient) are subject to the Hospital Deductible.

** PCP referrals are not required to obtain Covered Services however] Certain Covered Services require Prior Authorization and approval by Coventry's Medical Management Program. Please refer to the Certificate of Coverage for further details on Prior Authorization requirements.

Out-of-Pocket Maximums include copayment, deductibles and coinsurance amounts.

Services must be rendered within the Coventry network. Coventry participating physicians and providers have contracted with Coventry to provide care to our members.

This is a Schedule of Benefits only. Please refer to the Certificate of Coverage for complete details on the plan.

Benefit Summary

ASO - Choice Plus
City of Hialeah Sworn Police
Traditional with Deductible - 25/0/90% Plan 7EK

UnitedHealthcare and City of Hialeah want to help you take control and make the most of your health care benefits. That why we provide convenient services to get your health care questions answered quickly and accurately:

- Check personalized data: Find individualized information on your benefit coverage, check the status of claims, and search for physicians and hospitals using **www.myuhc.com**®.
- Researching health information: Find resources by logging on to www.myuhc.com.
- Get help: Contact Customer Care at the telephone number on the back of your ID card when you need assistance locating physicians and other health care professionals in your network, or when you have coverage or benefit questions.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	No Annual Deductible	$750 per year
Family Deductible	No Annual Deductible	$2,250 per year
> Member Copayments do not accumulate towards the Deductible.		
Out-of-Pocket Maximum		
Out-of-Pocket Maximum per Individual	$3,000 per year	$6,000 per year
> The Out-of-Pocket Maximum includes the Annual Deductible.		
> Member Copayments do not accumulate towards the Out-of-Pocket Maximum.		
Benefit Plan Coinsurance - The Amount the Plan Pays		
	90%	70% after Deductible has been met.

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD 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.

SFXGL7EK07

Item#	Rev. Date	Benefit Accumulator
XXX-XXXX	0708	Calendar Year

Lifetime Maximum Benefit

The maximum amount the Plan will pay during the entire period of time you are enrolled under the Plan.	Unlimited

Information on Benefit Limits

> The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis.

> All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Summary Plan Description.

> When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.

BENEFITS

Types of Coverage	**Network Benefits**	**Non-Network Benefits**
Ambulance Service - Emergency and Non-Emergency		
Ground Ambulance	$25 copayment per transport	$25 copayment per transport.
Air Ambulance Only one round trip for injury or Illness is allowed. Maximum benefit payable for newborn is $1,000	$25 copayment per transport. *Pre-service Notification is required for Non-Emergency Ambulance.*	$25 copayment per transport. *Pre-service Notification is required for Non-Emergency Ambulance.*
Cancer Resource Services (CRS)		
	90% The Plan pays Benefits for oncology services provided by a Designated Facility in the CRS program. Call CRS toll-free at (866) 936-6002 or visit www.urncrs.com	Non-Network Benefits are not available

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Clinical Trials		
Participation in a qualifying clinical trial for the treatment of: Cancer; Cardiovascular (cardiac/stroke); Surgical musculoskeletal disorders of the spine, hip and knees	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	Pre-service Notification is required.	*Pre-service Notification is required.*
Congenital Heart Disease (CHD) Surgeries		
	90%	70% after Deductible has been met. *Pre-service Notification is required.*
Dental Services - Accident Only		
Benefits are limited as follows: $3,000 maximum per year; $900 maximum per tooth	90% *Pre-service Notification is required.*	90% *Pre-service Notification is required.*
Oral Surgery/Wisdom Teeth: Impacted tooth removal Maximum payable per tooth $50.00	90%	70% after Deductible has been met.
Diabetes Services		
Diabetes Self Management and Training; Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
Diabetes Self Management Items	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under Durable Medical Equipment and in the Outpatient Prescription Drug Section of the SPD.	*Pre-service Notification is required for Durable Medical Equipment and Diabetes Equipment in excess of $1,000.*
Durable Medical Equipment (DME)		
Benefits are limited as follows:	90%	70% after Deductible has been met. *Pre-service Notification is required for Durable Medical Equipment in excess of $1,000.*
Emergency Health Services - Outpatient		
	100% after you pay a $30 Copayment per visit.	100% after you pay a $30 Copayment per visit. *Pre-service Notification is required if results in an Inpatient Stay.*

Types of Coverage	Network Benefits	Non-Network Benefits
Home Health Care		
Benefits are limited as follows: 60 visits per year	90%	70% after Deductible has been met. *Pre-service Notification is required.*
Hospice Care		
	90%	70% after Deductible has been met. *Pre-service Notification is required for Inpatient stays.*
Hospital - Inpatient Stay		
	90%	70% after Deductible has been met. *Pre-service Notification is required.*
Infertility Services		
Benefits are limited as follows: $5,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the plan. In Vitro Fertilization (One procedure only)	90% *Pre-service Notification is required.*	70% after Deductible has been met. *Pre-service Notification is required.*
Kidney Resource Services (KRS)		
	90% The Plan pays Benefits for End Stage Renal Disease (ESRD) and chronic kidney disease provided by a Designated Facility in the KRS program. Call KRS toll-free at (888) 936-7246 and select the KRS prompt.	Non-Network Benefits are not available
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	90%	70% after Deductible has been met.
Lab, X-Ray and Major Diagnostics - CT, PET, MRI and Nuclear Medicine - Outpatient		
	90%	70% after Deductible has been met.

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Mental Health and Substance Abuse Services - Inpatient and Intermediate		
	90%	70% after Deductible has been met.
	Prior Authorization is required from the MH/SA Designee.	*Prior Authorization is required from the MH/SA Designee.*
Mental Health and Substance Abuse Services - Outpatient		
	100% after you pay a $25 Copayment per visit.	70% after Deductible has been met.
Ostomy Supplies		
	90%	70% after Deductible has been met.
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office and by a Home Health Agency.	90%	70% after Deductible has been met.
Physician Fees for Surgical and Medical Services		
	90%	70% after Deductible has been met.
Physician's Office Services - Sickness and Injury		
Primary Physician Office Visit	100% after you pay a $25 Copayment per visit.	70% after Deductible has been met.
Specialist Physician Office Visit	100% after you pay a $35 Copayment per visit.	70% after Deductible has been met.

> **Only Office Visit Copayment** applies when these services are done during an office visit setting : CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Pregnancy - Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
	For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	*Pre-service Notification is required if the Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.*
Preventive Care Services		
Preventive Benefit Services as mandated by health care reform legislation		
Primary Physician Office Visit	100%	70% after Deductible has been met.
Specialist Physician Office Visit	100%	70% after Deductible has been met.
Lab, X-Ray or other preventive tests	100%	70% after Deductible has been met.
Private Duty Nursing – Outpatient		
	90%	70% after Deductible has been met.
Prosthetic Devices		
	90%	70% after Deductible has been met.
Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment		
Benefits are limited as follows: Spinal Manipulation Calendar Year Maximum $500 physical therapy- unlimited occupational therapy-unlimited speech therapy-unlimited (Includes coverage for non-restorative only for medical condition, not speech delay.) pulmonary rehabilitation-unlimited cardiac rehabilitation-unlimited post-cochlear implant aural therapy- unlimited	90%	70% after Deductible has been met. *Pre-service Notification is required for certain services.*

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Scopic Procedures - Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy, Sigmoidoscopy, Endoscopy	90%	70% after Deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	90%	70% after Deductible has been met. *Pre-service Notification is required.*
Surgery - Outpatient		
	90%	70% after Deductible has been met.
Temporomandibular Joint Services		
Must be medically Necessary.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Pre-service Notification is required.*
Therapeutic Treatments - Outpatient		
Therapeutic treatments include, but are not limited to: Dialysis, Intravenous chemotherapy or other intravenous infusion therapy, Radiation oncology	90%	70% after Deductible has been met. *Pre-service Notification is required for certain services.*
Transplantation Services		
	90% For Network Benefits, services must be received at a Designated Facility. *Pre-service Notification is required.*	70% after Deductible has been met. *Pre-service Notification is required.*
Travel and Lodging		
	Not covered	

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Urgent Care Center Services		
	100% after you pay a $30 Copayment per visit.	70% after Deductible has been met.
> In addition to the visit Copayment, the applicable Copayment or Deductible/Coinsurance applies when these services are done: CT, PET, MRI, Nuclear Medicine; Pharmaceutical Products; Scopic Procedures; Surgery; Therapeutic Treatments.		
Massotherapy		
$2,600 Calendar Year Maximum	100% after you pay a $25 Copayment per visit. *Pre-service Notification is required*	70% after Deductible has been met. *Pre-service Notification is required*
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	*Pre-service Notification is required*
Medical Supplies and Appliances		
Includes coverage for: Catheter Supplies Stockings/(Job/Compression) 2 pair per year Shoe Orthotics (based on Medical Necessity) Cranial Banding (based on Medical Necessity) Cochlear Implants (based on Medical Necessity)	90%	70% after Deductible has been met
Nutritional Formula/Supplements		
Coverage is only available if this is the only source of nutrition.	90%	70% after Deductible has been met

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD 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.

MEDICAL EXCLUSIONS

It is recommended that you review your SPD 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; rolfing (holistic tissue massage); art, music, dance, 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 Treatment and osteopathic care for which Benefits are provided as described in the SPD.

Dental

Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. 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. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: restoration, and replacement of teeth; medical or surgical treatment 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 the SPD. 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 the SPD. Dental braces (orthodontics). Treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

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 some types of braces, including over-the-counter orthotic braces. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm;home coagulation testing equipment; non-wearable external defibrillator; trusses; ultrasonic nebulizers; and ventricular assist devices. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophogeal voice prosthetics. Oral appliances for snoring. This exclusion does not apply to breast prosthesis, mastectomy bras and for which Benefits are provided as described under Reconstructive Procedures in the SPD.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. 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.

Experimental, Investigational or Unproven Services

Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.

Foot Care

Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot ca for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when neede for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. 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.

Medical Supplies and Equipment

Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: ace bandages, diabetic strips, and syringes; and ostomy bags and related supplies. This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD.
- Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD.

Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and the replacement of lost or stolen Durable Medical Equipment and deodorants, filters lubricants, tape, appliance clears, adhesive, or adhesive remover or other items that are not specifically identified in the SPD.

Mental Health / Substance Abuse

Inpatient, intermediate or outpatient care services that were not pre-authorized by the Mental Health/ Substance Abuse (MH/SA) Administrator; Services performed in connection with conditions not classified in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. Treatment for conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Administrator. Services utilizing methadone, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents as maintenance treatment for drug addiction. Treatment provided in connection with involuntary commitments, police detentions and other similar arrangements ,unless authorized by the Mental Health/Substance Abuse Administrator. Routine use of psychological testing without specific authorization; pastoral counseling. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/ Substance Abuse Administrator, typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective, or are not consistent with:

- Prevailing national standards of clinical practice for the treatment of such conditions.
- Prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- The Mental Health/Substance Abuse Administrator's level of care guidelines as modified from time to time.

The Mental Health/Substance Abuse Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria. Services for the treatment of mental illness or mental health conditions and substance abuse services and chemical dependency services that City of Hialeah has elected to provide through a separate benefit Plan; and treatment provided in connection with involuntary commitments, police detentions and other similar arrangements,unless pre-authorized by the mental health/ substance abuse administrator.

Nutrition

Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Nutritional Counseling in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

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 and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.

Physical Appearance

Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; 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 intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. 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. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations. 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. Chiropractic treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Chiropractic treatment (the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function).Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity even if there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Treatment of tobacco dependency. Chelation therapy, except to treat heavy metal poisoning.

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 ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. 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. Foreign language and sign language interpreters.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reasc for the treatment. This exclusion does not apply to in-vitro or services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. 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 elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).Contraceptive supplies and services. Fetal reduction surgery, except as described under Congenital Heart Disease (CHD) Surgeries in the SPD. Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. 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.

Transplants

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD. Mechanical or anim organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart whi the patient waits for a suitable donor heart to become available); and transplants that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants; and donor costs for organ or tissue transplantation to another person (these contest may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care; domiciliary care. Private duty nursing received on an inpatient basis. Respite care; 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 associated fitting charge for eye glasses and contact lenses. Routine vision examinations, including refractive examinations to determine the need for vision correction. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices. Eye exercise therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of career, education, school, sports or camp, travel, employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; 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. Health services received after the date your coverage under the Plan 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 Plan ended. 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 Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Health services when a provider waives the Copay,Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/ hyperactively disorder; TBI; or dyslexia.

Preexisting Conditions

Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months. This exclusion does not apply to children from 0 to 19 years of age.

Pre-Existing is defined as follows:
6/6/12/12 -
6 - No diagnosis or treatment for the employee, 6 months prior to enrolling in coverage.
6 - No diagnosis or treatment for the dependent, 6 months prior to enrolling in coverage.
12 - The maximum amount of months that an employee would be enrolled in coverage before the condition would no longer be treated as a pre-existing condition.
12 – The maximum amount of months that a dependent would be enrolled in coverage before the condition would no longer be treated as a pre-existing condition.

UnitedHealthcare®

A UnitedHealth Group Company

Benefit Summary

Outpatient Prescription Drug

ASO

City of Hialeah

10/30/50 Plan 0H9

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **www.myuhc.com®** or calling Customer Care at the telephone number on the back of your ID card.

Annual Drug Deductible - Network and Non-Network	
Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Maximum - Network and Non-Network	
Individual Out-of-Pocket Maximum	No Out-of-Pocket Drug Maximum
Family Out-of-Pocket Maximum	No Out-of-Pocket Drug Maximum

This summary of Benefits is intended only to highlight your Benefits for Prescription Drugs and should not be relied upon to determine coverage. Your plan may not cover all of your Prescription Drug expenses. Please refer to the Prescription Drug section of the Summary Plan Description (SPD) for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Prescription Drug section of the SPD, the Prescription Drug section of SPD shall prevail.

SFXRP0H907

Item# **Rev. Date**

XXX-XXXX 0908

Tier Level	Retail Up to 31-day supply		*Mail Order Up to 90-day supply
	Network	**Non-Network**	**Network**
Tier 1	**$10**	**$10**	**$20**
Tier 2	**$30**	**$30**	**$60**
Tier 3	**$50**	**$50**	**$100**
Specialty Prescription Drugs – up to 31 days	**$10 Copay** **$30 Copay** **$50 Copay**		

* Only certain Prescription Drug Products are available through mail order; please visit www.myuhc.com or call Customer Care at the telephone number on the back of your ID card for more information.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or your provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tier drug.

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

CITY OF HIALEAH, FLORIDA
RISK MANAGEMENT DIVISION
MEMORANDUM

To: All Members currently enrolled in the City's Self Funded Group Health Plan

From: Robert Lloyd-Still, Risk Manager

Date: October 11, 2011

Subject: Medicare Part D Prescription Coverage

Important Notice from the City of Hialeah Self-Funded Group Health Plan 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 City of Hialeah Self-Funded Plan and 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 City of Hialeah has determined that the prescription drug coverage offered by the City of Hialeah Self-Funded Plan 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 City of Hialeah Self-Funded Plan coverage will not be affected. If you do decide to enroll in a Medicare prescription drug plan and drop your City of Hialeah Self-Funded Plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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 current coverage with City of Hialeah Self-Funded Plan 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 October to join.

For more information about this notice or your current prescription drug coverage...

Contact our office at 305-883-8059 for further information or call United Healthcare at 1-800-842-2038. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the City of Hialeah Self-Funded Plan changes. You may also request a copy 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 drug plans.

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).

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).

Date:	*October 11, 2011*
Name of Entity/Sender:	*City of Hialeah Self-Funded Plan*
Contact--Position/Office:	*Risk Management Office*
Address:	*501 Palm Avenue, Hialeah, Florida 33010*
Phone Number:	*305-883-8059*

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

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 January 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/ TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529 **ARIZONA** – CHIP Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARKANSAS – CHIP	**FLORIDA** – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268

NOTICE ABOUT THE EARLY RETIREE REINSURANCE PROGRAM

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.