

Williamson County

Choice EPO Plan (Self-Funded HMO)

To keep you in control of your health care decisions, Choice plan gives you the freedom to see any doctor in the network, including specialists, without a referral.

With Choice plan, the vast majority of your health care needs are covered with little or no out-of-pocket costs when you visit a network doctor or facility. Plus, when you visit network doctors and hospitals, there aren't any submissions of claim forms for you to worry about.

Some of the Important Benefits of Choice Plan include:

Visit any doctor in the Choice network across the country, including specialists, without designating a primary physician.

Visit any network hospital across the country.

Emergencies are covered anywhere in the world.

Benefits are available for in-network office visits and in-network hospital care, as well as in-network inpatient and outpatient surgery, when covered health services are provided.

Prenatal care is included.

Routine check-ups are included.

Childhood immunizations are provided.

Mammograms are included.

Pap smears are included.

Hearing screenings are covered.

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

Choice Benefits Summary

Types of Coverage	Network Benefits /Copayment Amounts/Your Responsibility
<p>This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.</p> <p>If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail.</p> <p>Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description.</p> <p>Network health care services under this benefit plan are covered only when provided, arranged, or authorized by a Network Physician.</p> <p>*Prior Notification is required for certain services.</p>	<p>Annual Deductible: \$300 per Covered Person per calendar year, not to exceed \$900 for all Covered Persons in a family</p> <p>Out-of-Pocket Maximum: \$1,500 per Covered Person per calendar year, not to exceed \$4,500 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for Covered Health Services will not apply to the Out-of-Pocket Maximum.</p> <p>Maximum Plan Benefit: \$5,000,000 per Covered Person</p>
<p>1. Ambulance Services - Emergency only</p>	<p>Ground Transportation: 10% of Eligible Expenses after Deductible</p> <p>Air Transportation: 10% of Eligible Expenses after Deductible</p>
<p>2. Dental Services - Accident only</p>	<p>10 % of Eligible Expenses after Deductible</p> <p>*Prior notification is required before follow-up treatment begins.</p>
<p>3. Durable Medical Equipment Benefits for Durable Medical Equipment are limited to \$5,000 per calendar year.</p>	<p>10% of Eligible Expenses after Deductible</p>
<p>4. Emergency Room Health Services</p>	<p>\$225 per visit</p>
<p>5. Home Health Care Benefits are limited to \$15,000 per calendar year.</p>	<p>Covered at 100%, of Eligible Expenses, No Deductible applies</p>
<p>6. Hospice Care Benefits are limited to \$20,000 during the entire period of time a Covered Person is covered under the plan.</p>	<p>Covered at 100%, of Eligible Expenses, No Deductible applies</p>
<p>7. Hospital - Inpatient Stay</p>	<p>10 % of Eligible Expenses after Deductible</p>
<p>8. Injections Received in a Physician's Office</p> <p>Allergy Injections</p>	<p>PCP:\$25 per visit Specialist: \$40 per visit</p> <p>Childhood immunizations birth to 6 years old: No Copayment</p> <p>10% of Eligible Expenses after Deductible</p>
<p>9. Maternity Services Primary Care Physician (Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrician):</p> <p>Specialist:</p> <p>Hospital – Inpatient Stay:</p> <p>Outpatient Diagnostic For Lab and Radiology/X-Ray:</p> <p>Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine:</p> <p>Professional Fees for Surgical and Medical Services:</p>	<p>\$25 per visit</p> <p>\$40 per visit</p> <p>No Copayment applies to Physician office visits for prenatal care after the first visit.</p> <p>10% of Eligible Expenses after Deductible</p> <p>No Copayment</p> <p>10% of Eligible Expenses after Deductible</p> <p>10% of Eligible Expenses after Deductible</p>

YOUR BENEFITS

Types of Coverage	Network Benefits /Copayment Amounts/Your Responsibility
10. Outpatient Surgery, Diagnostic and Therapeutic Services	
Outpatient Surgery	10% of Eligible Expenses after Deductible
Outpatient Diagnostic Services	For lab and radiology/Xray: No Copayment
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	10% of Eligible Expenses after Deductible
Outpatient Therapeutic Treatments	10% of Eligible Expenses after Deductible
11. Physician's Office Services (Preventive/Sickness/Injury) Including well baby care, well woman visit, family planning, routine physicals and immunizations, maternity pre and postnatal.	Primary Care Physician (Family Practice, General Practice, Internal Medicine, OB/Gyn, Pediatrician): \$25 per visit Specialist: \$40 per visit Childhood immunizations birth to 6 years old: No Copayment No Copayment applies when a Physician charge is not assessed.
12. Professional Fees for Surgical and Medical Services	10% of Eligible Expenses after Deductible
13. Prosthetic Devices Benefits for Prosthetic Devices are limited to \$5,000 per calendar year.	10% of Eligible Expenses after Deductible
14. Reconstructive Procedures Physicians Office Services Primary Care Physician (Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrician): Specialist: Hospital – Inpatient Stay: Outpatient Surgery: Outpatient Diagnostic For Lab and Radiology/X-Ray: Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine: Professional Fees for Surgical and Medical Services: Prosthetic Devices:	\$25 per visit \$40 per visit No Copayment applies when a Physician charge is not assessed. 10% of Eligible Expenses after Deductible 10% of Eligible Expenses after Deductible No Copayment 10% of Eligible Expenses after Deductible 10% of Eligible Expenses after Deductible 10% of Eligible Expenses after Deductible
15. Rehabilitation Services -Outpatient Therapy Benefits are limited as follows: 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 20 visits of pulmonary rehabilitation; and 36 visits of cardiac rehabilitation per calendar year.	\$25 per visit
16. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Benefits are limited to \$15,000 per calendar year.	Covered at 100%, No Deductible applies
17. Transplantation Services	10% of Eligible Expenses after Deductible
18. Urgent Care Center Services	\$40 per visit
Additional Benefits	
Mental Health and Substance Abuse Services – Outpatient Must receive prior authorization through the Mental Health/Substance Abuse Designee. Benefits are limited to 20 visits per calendar year (60 visits for Serious Mental Illness).	10% of Eligible Expenses after Deductible

Types of Coverage	Network Benefits /Copayment Amounts/Your Responsibility
<p>Mental Health and Substance Abuse Services – Inpatient and Intermediate Must receive prior authorization through the Mental Health/Substance Abuse Designee. Benefits are limited to 30 days per calendar year(45 days for Serious Mental Illness). Chemical dependency limited to 3 series of treatment per lifetime.</p>	<p>10% of Eligible Expenses after Deductible</p>
<p>Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network Benefits are limited to \$1,000 per calendar year.</p>	<p>10% of Eligible Expenses after Deductible</p>
<p>Diabetes Management Training and Supplies Physicians Office Services Primary Care Physician (Family Practice, General Practice, Internal Medicine, OB/GYN, Pediatrician):</p> <p>Specialist:</p> <p>Hospital – Inpatient Stay:</p> <p>Outpatient Surgery:</p> <p>Outpatient Diagnostic For Lab and Radiology/X-Ray:</p> <p>Outpatient Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine:</p> <p>Professional Fees for Surgical and Medical Services:</p> <p>Prosthetic Devices:</p>	<p>\$25 per visit</p> <p>\$40 per visit</p> <p>No Copayment applies when a Physician charge is not assessed.</p> <p>10% of Eligible Expenses after Deductible</p> <p>10% of Eligible Expenses after Deductible</p> <p>No Copayment</p> <p>10% of Eligible Expenses after Deductible</p> <p>10% of Eligible Expenses after Deductible</p> <p>10% of Eligible Expenses after Deductible</p>
<p>Temporomandibular Joint Services Diagnostic and surgical treatment of conditions affecting the temporomandibular joint (TMJ). This includes the jaw and the craniomandibular joint. Coverage is to be provided for medically necessary treatment resulting from:</p> <ol style="list-style-type: none"> 1.) An accident; 2.) A trauma; 3.) A congenital defect; 4.) A developmental defect; 5.) A Pathology. 	<p>10% of Eligible Expenses after Deductible</p>

Exclusions

Except as may be specifically provided in Section 1 of the Summary Plan Description (SPD) or through a Rider to the SPD, the following are not covered:

A. Alternative Treatments

Acupressure; hypnosis; rolfing; massage therapy; aroma therapy; acupuncture; and other forms of alternative Treatment.

B. Comfort or Convenience

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

C. Dental

Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations) are excluded, except anesthesia as might otherwise be required for transplant preparation, initiation of immunosuppressives, the direct treatment of acute traumatic injury, cancer, or cleft palate, or dental appliances when part of treatment for documented obstructive sleep apnea. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

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

E. Experimental, Investigational or Unproven Services

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

F. Foot Care

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

G. Medical Supplies and Appliances

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

H. Mental Health/Substance Abuse

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

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

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

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk, except for PKU.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure.

United HealthCare Insurance Company

(Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services 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 as further described in Section 2 of the SPD (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments.

Surrogate parenting. The reversal of voluntary sterilization.

M. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

N. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the SPD. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

O. Travel

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

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

P. Vision and Hearing

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

Q. Other Exclusions

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

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

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

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

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

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

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

Growth hormone therapy; sex transformation operations; treatment of benign gynecosmastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment, or oral appliances for snoring, except when provided as part of treatment for documented obstructive sleep apnea.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

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

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ASO

Pharmacy Management Program

EPO (Choice)

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

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

Copayment per Prescription Order or Refill

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

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

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

	Retail Network Pharmacy For up to a 31 day supply	Home Delivery Network Pharmacy For up to a 90 day supply
Tier 1	\$10	\$20
Tier 2	\$30	\$60
Tier 3	\$50	\$100

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Other Important Cost Sharing Information

Annual Drug Deductible

No Annual Drug Deductible

Out-of-Pocket Drug Maximum

No Out-of-Pocket Drug Maximum

Exclusions

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

Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

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

Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility. Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

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

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

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

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

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

Unit dose packaging of Prescription Drug Products.

Medications used for cosmetic purposes.

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

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

Prescription Drug Products when prescribed to treat infertility.

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

Prescription Drug Products for smoking cessation.

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

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

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

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