

CITY OF SANTA FE

"REQUEST FOR PROPOSALS"

Third Party Administration for Self-Funded Medical Plan*
Stop Loss Coverage
Flexible Spending Account (FSA) Administration
COBRA Administration
Wellness Program
Voluntary Vision Insurance Coverage

***Due to the fact that the City of Santa Fe is deliberating changes to its plan design(s), Fully Insured Coverage Providers are welcome to provide a proposal as well. Under discussion, among other things are, member eligibility, increases in co-pays; deductibles and/or co-insurance percentages. Proposers should include in their proposal any monetary, service, and/or notables regarding the effect these changes could have on proposers' response.**

RFP #15/24/P

PROPOSAL DUE:

**February 23, 2015
2:00 P.M.
PURCHASING OFFICE
CITY OF SANTA FE
2651 SIRINGO ROAD
BUILDING "H" SANTA FE,
NEW MEXICO 87505**

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1. Instructions Relating to Local Preference Certification Form
2. Local Preference Certification Form
3. Resident Veterans Preference Certification
4. Sample Contract
5. Minimum Wage Ordinance
6. Supplemental Information:
 - a. Executive Performance Report
 - b. Summary of Benefits & Coverage
 - c. City of Santa Fe Wellness Program Update (12/30/14)
 - d. UnitedHealthcare Vision

REQUEST FOR PROPOSALS

PROPOSAL NUMBER '15/24/P

Proposals will be received by the City of Santa Fe and shall be delivered to the City of Santa Fe Purchasing Office, 2651 Siringo Road Building "H" Santa Fe, New Mexico 87505 **until 2:00 P.M. local prevailing time, February 23, 2015.** Any proposal received after this deadline will not be considered. This proposal is for the purpose of procuring professional services for the following:

**Third Party Administration City of Santa Fe Self-Funded
Employee Health Insurance Program
Flexible Spending Account (FSA) Administration
Wellness Program, COBRA
and Voluntary Vision Insurance Program**

The proponent's attention is directed to the fact that all applicable Federal Laws, State Laws, Municipal Ordinances, and the rules and regulations of all authorities having jurisdiction over said item shall apply to the proposal throughout, and they will be deemed to be included in the proposal document the same as though herein written out in full.

The City of Santa Fe is an Equal Opportunity Employer and all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, sexual orientation or national origin. The successful proponent will be required to conform to the Equal Opportunity Employment regulations.

Proposals may be held for sixty (60) days subject to action by the City. The City reserves the right to reject any of all proposals in part or in whole. Proposal packets are available by contacting: Shirley Rodriguez, City of Santa Fe, Purchasing Office, 2651 Siringo Road, Building "H" Santa Fe, New Mexico, 87505, (505) 955-5711.



Robert Rodarte, Purchasing Officer

Received by the Santa Fe New Mexican Newspaper on: 01/16/15
To be published on: 01/22/15

Received by the Albuquerque Journal Newspaper on: 01/16/15
To be published on: 01/22/15

PROPOSAL SCHEDULE

RFP # '15/24/P

1. Advertisement January 22, 2015
2. Issuance of RFP'S: January 22, 2015
3. Receipt of proposals:
February 23, 2015
at 2:00 p.m.
local prevailing time.
Purchasing Office 2651
Siringo Road Bldg., "H"
Santa Fe, New Mexico
87505 (505) 955-5711
4. Evaluation of proposals: March 2, 2015
5. Interviews: March 9, 2015
6. Recommendation of award
to Finance Committee: March 30, 2015
7. Recommendation of award
to City Council: April 8, 2015

DATES HELD WITHIN THE PROPOSAL SCHEDULE POST RFP SUBMITTAL AND CONSIDERATION OF CONSIDERATION BY FINANCE COMMITTEE AND CITY COUNCIL ARE TENTATIVE AND SUBJECT TO CHANGE WITHOUT NOTICE.

INFORMATION FOR PROPONENTS

1. RECEIPT OF PROPOSALS

The City of Santa Fe (herein called "City"), invites firms to submit one original and 10 copies of the proposal. Proposals will be received by the Purchasing Office, until 2:00 p.m. local prevailing time, February 23, 2015.

The packets shall be submitted and addressed to the Purchasing Office, at 2651 Siringo Road Bldg. "H" Santa Fe, New Mexico 87505. No late proposals will be accepted whether hand delivered, mailed or special delivery. Do not rely on "overnight delivery" without including some lead-time. "Overnight delivery" will be determined to be non-responsive if delivered late, no matter whose fault it was. It is recommended that extra days be included in the anticipated delivery date to ensure delivery is timely. The Purchasing Office is closed 12:00 p.m. to 1:00 p.m. The outside of the envelope should clearly indicate the following information:

Proposal number: '15/24/P
Title of the proposal: TPA City of Santa Fe Self-Funded medical Ins. Program
Name and address of the proponent:

Any proposal received after the time and date specified shall not be considered. No proposing firm may withdraw a proposal within 60 days after the actual date of the opening thereof.

2. PREPARATION OF PROPOSAL

Vendors shall comply with all instructions and provide all the information requested. Failure to do so may disqualify your proposal. All information shall be given in ink or typewritten. Any corrections shall be initialed in ink by the person signing the proposal.

This request for proposal may be canceled or any and all proposals may be rejected in whole or in part, whenever the City of Santa Fe determines it is in the best interest of the city.

3. ADDENDA AND INTERPRETATIONS

No oral interpretation of the meaning of any section of the proposal documents will be binding. Oral communications are permitted in order to make an assessment of the need for an addendum. Any questions concerning the proposal must be addressed prior to the date set for receipt of proposal.

Every request for such interpretations should be in writing addressed to, Purchasing Officer, 2651 Siringo Road Bldg. "H" Santa Fe, New Mexico, 87505 and to be given consideration must be received at least (5) days prior to the date set for the receiving of proposals.

Any and all such interpretations and any supplemental instruction will be in the form of written addenda to the RFP, which if issued, will be delivered to all prospective firms not later than three days prior to the date fixed for the receipt of the proposals. Failure of any proposing firm to receive any such addenda or interpretations shall not relieve such firm from any obligation under their proposal as submitted. All addenda so issued shall become part of the contract documents.

The City reserves the right to not comply with these time frames if a critical addendum is required or if the proposal deadline needs to be extended due to a critical reason in the best interest of the City of Santa Fe.

4. LAWS AND REGULATIONS

The proposing firm's attention is directed to the fact that all applicable Federal Laws, State Laws, Municipal Ordinances, and the rules and regulations of all authorities having jurisdiction over said item shall apply to the contract throughout. They will be deemed to be included in the contract the same as though herein written out in full.

5. METHOD OF AWARD

The proposal is to be awarded based on qualified proposals as per the enclosed rating system and at the discretion and consideration of the governing body of the City of Santa Fe. The selection committee may interview the top three rated proponents; however, contracts may be awarded without such interviews. At its discretion the city reserves the right to alter the membership or size of the selection committee. The City reserves the right to change the number of firms interviewed.

6. COMPLIANCE WITH CITY'S MINIMUM WAGE RATE ORDINANCE (LIVING WAGE ORDINANCE)

A copy of the City of Santa Fe Ordinance No. 2003-8, passed by the Santa Fe City Council on February 26, 2003 is attached. The proponent or bidder will be required to submit the proposal or bid such that it complies with the ordinance to the extent applicable. The recommended Contractor will be required to comply with the ordinance to the extent applicable, as well as any subsequent changes to the Ordinance throughout the term of this contract.

7. RESIDENT and LOCAL PREFERENCE

INTENT AND POLICY

The city recognizes that the intent of the state resident preference statute is to give New Mexico businesses and contractors an advantage over those businesses, manufacturers and contractors from outside the State of New Mexico. The underlying policy is to give a preference to those persons and companies who contribute to the economy of the State of New Mexico by maintaining businesses and other facilities within the state and giving employment to residents of the state (1969 OP. Att'y Gen. No. 69-42). The city also has adopted a policy to include a local preference to those persons and companies who

contribute to the economy of the County of Santa Fe by maintaining businesses and other facilities within the county and giving employment to residents of the county.

APPLICATION-IN-STATE AND OUT OF STATE BIDDERS

With acknowledgment of this intent and policy, the preference will only be applied when bids are received from in-state and county businesses, manufacturers and contractors that are within 5% of low bids received from out-of-state businesses, manufacturers and contractors (13-1-21 (A) -1-21 (F) and 13-4-2 (C) NMSA 1978).

To be considered a resident for application of the preference, the in-state bidder must have included a valid state purchasing certification number with the submitted bid.

Thus it is recommended that in-state bidders obtain a state purchasing certification number and use it on all bids, in order to have the preference applied to their advantage, in the event an out-of-state bid is submitted. In submitting a bid, it should never be assumed that an out-of-state bid will not be submitted.

For information on obtaining a state purchasing certification number, the potential bidder should contact the State of New Mexico Taxation and Revenue Department.

All resident preferences shall be verified through the State Purchasing Office. Applications for resident preference not confirmed by the State Purchasing Office will be rejected. The certification must be under the bidder's business name submitting the bid.

NON-APPLICATION-COMPETING IN-STATE BIDDERS

If the lowest responsive bid and the next responsive bids within 5% of the lowest bid, are all from the state of New Mexico, then the resident preference will not be applied and the state purchasing certification number will not be considered. To be considered an in-state bidder in this situation, the bidders must meet the definition criteria of Chapter 13-1-21 (A)(1) and Chapter 13-4-2 (A) NMSA 1978. After examining the information included in the bid submitted, the City Purchasing Officer may seek additional information of proof to verify that the business is a valid New Mexico business. If it is determined by the city Purchasing Officer that the information is not factual and the low responsive bid is actually an out-of-state bidder and not a New Mexico business, then the procedures in the previous section may be applied.

If the bidder has met the above criteria, the low responsive "resident" bid shall be multiplied by .95. If that amount is then lower than the low responsive bid of a "non-resident" bidder, the award will be based taking into consideration the resident preference of 5%.

APPLICATION FOR LOCAL PREFERENCE

For the purposes of this section, the terms resident business and resident manufacturer shall be defined as set out in Section 13-1-21 NMSA 1978; the term local as applied to a business or manufacturer shall mean:

Principal Office and location must be stated: To qualify for the local preference, the principal place of business of the enterprise must be physically located within the Santa Fe County Geographic Boundaries. The business location inserted on the Form must be a physical location, street address or such. DO NOT use a post office box or other postal address. Principal place of business must have been established no less than six months preceding application for certification.

The PREFERENCE FACTOR for resident and local preferences applied to bids shall be .95 for resident and .90 for local. The preference for proposals shall be 1.05 for resident and 1.10 for local.

New Mexico Resident Veteran Business Preference: New Mexico law, Section 13-1-22 NMSA 1978, provides a preference in the award of a public works contract for a "resident veteran business". Certification by the NM Department of Taxation and Revenue for the resident veteran business requires the Offeror to provide evidence of annual revenue and other evidence of veteran status.

An Offeror who wants the veteran business preference to be applied to its proposal is required to submit with its proposal the certification from the NM Department of Taxation and Revenue and the sworn affidavit attached hereto as Appendix E.

If an Offeror submits with its proposal a copy of a valid and current veteran resident business certificate, 7%, 8%, or 10% of the total weight of all the evaluation factors used in the evaluation of proposal may be awarded.

The local preference or resident business preference is not cumulative with the resident veteran business preference.

Proposals for Goods and Services. When proposals for the purchase of goods or services pursuant to Section 23 are received, the evaluation score of the proposal receiving the highest score of all proposals from those proponents in the first category listed above shall be multiplied by the Preference Factor. If the resulting score of that proposal receiving the preference is higher than or equal to the highest score of all proposals received, the contract shall be recommended to that proponent receiving the preference. If no proposals are received from proponents in the first category, or if the proposal receiving the preference does not qualify for an award after multiplication by the Preference Factor, the same procedure shall be followed with respect to the next category of proposals listed to determine if a proponent qualifies for award.

Qualifications for Resident Preference. No resident business or manufacturer, as defined, shall be given any preference in the awarding of contracts for furnishing goods or services to the city, unless it shall have qualified with the State Purchasing Agent as a resident business or manufacturer and obtained a certification number as provided in Section 13-1-22 NMSA 1978. The certification number must be submitted with its bid for an offeror to qualify for this preference. The Central Purchasing Office shall determine if a resident preference is applicable to a particular offer on a case by case basis.

Qualifications for Local Preference. The Central Purchasing Office shall have available a form to be completed by all bidders/proponents who desire to apply for the local preference

as a local business. The completed form with the information certified by the offeror must be submitted by the bidders/proponents with their bid or proposal to qualify for this preference.

Limitation. No offeror shall receive more than a 5% for resident and 10% for local preference pursuant to this section on any one offer submitted. A bidder may not claim cumulative preferences.

Application. This section shall not apply to any purchase of goods or services when the expenditure of federal and/or state funds designated for a specific purchase is involved and the award requirements of the funding prohibit resident and/or local preference(s). This shall be determined in writing by the department with the grant requirements attached to the Purchasing Office before the bid or request for proposals is issued.

Exception. The City Council at their discretion can approve waiving the Local Preference requirements for specific projects or on a case by case basis if it is the City's best interest to do so.

New Mexico Resident Preference Number (if applicable)_____

8. PROTESTS AND RESOLUTIONS PROCEDURES

Any proponent, offeror, or contractor who is aggrieved in connection with a procurement may protest to the Purchasing Officer. The protest must be in writing and submitted within fifteen (15) days and requirements regarding protest and resolution of protests are available from the Purchasing Office upon request.

SPECIAL CONDITIONS

1. GENERAL

When the City's Purchasing Officer issues a purchase order document in response to the vendor's bid, a binding contract is created.

2. ASSIGNMENT

Neither the order, nor any interest therein, nor claim under, shall be assigned or transferred by the vendor, except as expressly authorized in writing by the City Purchasing Officer's Office. No such consent shall relieve the vendor from its obligations and liabilities under this order.

3. VARIATION IN SCOPE OF WORK

No increase in the scope of work of services or equipment after award will be accepted, unless means were provided for within the contract documents. Decreases in the scope of work of services or equipment can be made upon request by the city or if such variation has been caused by documented conditions beyond the vendor's control, and then only to the extent, as specified elsewhere in the contract documents.

4. DISCOUNTS

Any applicable discounts should be included in computing the bid submitted. Every effort will be made to process payments within 30 days of satisfactory receipt of goods or services. The City Purchasing Officer shall be the final determination of satisfactory receipt of goods or services.

5. TAXES

The price shall include all taxes applicable. The city is exempt from gross receipts tax on tangible personal property. A tax exempt certificate will be issued upon written request.

6. INVOICING

(A) The vendor's invoice shall be submitted in duplicate and shall contain the following information: invoice number and date, description of the supplies or services, quantities, unit prices and extended totals. Separate invoices shall be submitted for each and every complete order.

(B) Invoice must be submitted to ACCOUNTS PAYABLE and NOT THE CITY PURCHASING AGENT.

7. METHOD OF PAYMENT

Every effort will be made to process payments within 30 days of receipt of a detailed invoice and proof of delivery and acceptance of the products hereby contracted or as otherwise specified in the compensation portion of the contract documents.

8. DEFAULT

The city reserves the right to cancel all or any part of this order without cost to the city if the vendor fails to meet the provisions for this order, and except as otherwise

provided herein, to hold the vendor liable for any excess cost occasioned by the city due to the vendor's default. The vendor shall not be liable for any excess cost if failure to perform the order arises out of causes beyond the control and with the fault or negligence of the Vendor and these causes have been made known to the City of Santa Fe in written form within five working days of the vendor becoming aware of a cause which may create any delay; such causes include, but are not limited to, acts of God or the public enemy, acts of the State or of the Federal Government, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, unusually severe weather and defaults of sub-contractors due to any of the above unless the city shall determine that the suppliers or services to be furnished by the sub-contractor are obtainable from other sources in sufficient time to permit the vendor to meet the required delivery schedule. The rights and remedies of the city are not limited to those provided for in this paragraph and are in addition to any other rights provided for by law.

9. NON-DISCRIMINATION

By signing this City of Santa Fe bid or proposal, the vendor agrees to comply with the Presidents Executive Order No. 11246 as amended.

10. NON-COLLUSION

In signing this bid or proposal, the vendor certifies they have not, either directly or indirectly, entered into action in restraint of full competition in connection with this bid or proposal submittal to the City of Santa Fe.

SCOPE OF SERVICES '15/24/P

1. Introduction

The City of Santa Fe, New Mexico is the City government entity of Santa Fe, New Mexico. This Request for Proposal (RFP) is being distributed for Third Party Administration services* for the employee medical plan, Stop Loss Insurance, COBRA Administration, FSA Administration, and Voluntary Vision. **Vendors can submit a proposal for any one or all of the requested services.**

***Due to the fact that the City of Santa Fe is deliberating changes to its plan design(s), Fully Insured Coverage Providers are welcome to provide a proposal as well. Under discussion for plan changes, among other things are, member eligibility, increases in co-pays; deductibles and/or co-insurance percentages. Proposers should include in their proposal any monetary, service, and/or notables regarding the effect these changes could have on proposers' response.**

This RFP contains specifications covering the claims administration for the self-insured portion of the City of Santa Fe medical insurance program, stop loss, COBRA, FSA Administration and Voluntary Vision. The City is seeking bids to match the current program in place on a self funded basis. Quotes should be net of commission and state premium tax for a July 1, 2015 effective date.

This RFP and all subsequent modifications are hereby designated as the sole reference and authority for the preparation of proposals. The release of this RFP supersedes all other documents which may exist related to the work to be done. The contents of this RFP and subsequent modifications take precedence over any and all information related to the claims administration of the insurance program obtained from any source, either by written or verbal communications. This RFP shall not be construed (1) to create an obligation on the part of City of Santa Fe to enter into a contract with any firm or (2) to serve as the basis of a claim for reimbursement for expenditures related to the development of a proposal.

2. Information and General Conditions

2.1 Signature

The proposal must be signed in the name of the TPA/vendor and must bear the original signature of the person authorized to sign proposals on behalf of the TPA/vendor.

2.2 Completion of Proposals

Proposals shall be completed in all respects as required by the instructions herein. A proposal will be rejected if, in the opinion of City of Santa Fe, the information contained was intended to erroneously and of fallaciously mislead City of Santa Fe in the evaluation of the proposal.

2.3 Cost of Preparation of Proposals

Costs for developing responses to this RFP are entirely the responsibility of the Proposers and shall not be chargeable to City of Santa Fe.

2.4 Evaluation Process

During the evaluation, validation and selection process, City of Santa Fe may request meetings with a Proposer's representative to request answers to specific questions or may request that they answer specific questions in writing. The City may require that the Proposers make presentations that are pertinent to the evaluation process.

2.5 Award of Contract

It is anticipated that award of the contract will be made within approximately sixty (60) days after the closing date for the Submission of Proposals. The City of Santa Fe reserves the right to revise the contract award date and also reserves the right to not award the contract.

2.6 Related Experience

All Proposers must submit information that indicates specific qualifications to complete the work to be done as defined herein. Each Proposer shall submit with their proposal a list of four (4) clients for whom similar work has been performed in the past four (4) years. The reference list shall include the names and addresses of the client, the name, title and telephone number of each client's cognizant manager, and the dates the work was performed. During the evaluation and selection process, City of Santa Fe may contact each of the referenced clients. Proposers are hereby advised that City of Santa Fe maintains the sole and exclusive right to determine whether or not the TPA can perform the work to be done.

2.7 Compliance with Laws

Proposers shall agree to comply with all applicable Federal, State and local laws, rules, regulations, ordinances, policies and procedures in the conduct of the program as specified herein.

2.8 Permits and Licenses

The Proposers, its employees and agents, shall be required to secure and maintain valid permits and licenses as required by law for the execution of services pursuant to this Proposal.

2.9 Professional Liability Coverage

Proposers shall provide proof of professional liability coverage.

2.10 Blanket Fidelity Bond

The Proposers shall be required to maintain a blanket fidelity bond in the amount not less than One Million Dollars (\$1,000,000) with an approved corporate surety covering any and all principals, officers and employees involved in the performance of the agreement.

2.11 Errors and Omissions Insurance

Proposers shall be required to maintain Errors and Omissions Insurance in an amount not less than One Million Fifty-Thousand Dollars (\$1,050,000) per occurrence and Two Million Dollars (\$2,000,000) aggregate. If the Proposers already have Errors and Omissions coverage, please specify: carrier, policy number, limits, and deductible and expiration date.

2.12 Proposals from Agents

Proposals from agents are not acceptable. All proposals must be submitted directly by the entity to be providing the services.

However, in the event that the City of Santa Fe makes changes to its eligibility for enrollment, it will want to have an avenue for the non-covered/non-eligible populations to find assistance in seeking individual health coverage. For these purposes only, proposals from Agents/Brokers certified through the CMS Federally Facilitated Marketplace available to assist individuals seeking health coverage, will be accepted. Adapt your proposal appropriately to indicate how you would provide this service, how the service benefits the City of Santa Fe, generally and specifically in assisting our non-covered/non-eligible populations. Identify the number of persons, and identify names and/or association as applicable, certified through the CMS Federally Facilitated Marketplace available to assist individuals seeking health coverage.

3. Statement of Work - Section A Medical Administration, Stop Loss, Flexible Spending Account, COBRA Administration, Wellness Program and Voluntary Vision coverage

Proposers shall perform all services required to provide network access, medical and pharmacy claims administration, and stop loss insurance under a self insured and/or minimum premium funding arrangement for the City of Santa Fe Self Funded Employee Health Program for its 1,250 covered employees for City of Santa Fe and to act as City of Santa Fe's representative in matters relating to City of Santa Fe's obligations under New Mexico law.

The City of Santa Fe currently offers three plans—Premium, Core and Value. The Premium and Core are traditional PPO plans. The Core is a High Deductible Health Plan with a Health Reimbursement Account (HRA). **The City of Santa Fe is deliberating changes to its plan design(s). Under discussion, among other things are, member eligibility, increases in co-pays; deductibles and/or co-insurance percentages. Proposers should include in their proposal any monetary, service, and/or notables regarding the effect these changes could have on proposers' response. Fully Insured Coverage Plans are welcome to submit a proposal for the Medical Service as well as any other portions they find applicable.**

The City has both Individual and Aggregate Stop Loss coverage. The ISL deductible is set at \$250,000. The ASL corridor is 125%.

The current ASO administrator provides Flexible Spending Account (FSA), Wellness Program, COBRA Administration and Voluntary Vision Insurance Coverage.

Proposers shall perform, but is not limited to, the following services on behalf of City of Santa Fe:

3.1 Medical TPA Services – (NOTE: Fully Insured Coverage Plans are welcome to submit proposals as well and should adjust their proposal appropriately to address the following questions)

- 3.1.1 Administer requested plan designs – premium, core and value HRA
- 3.1.2 Provide effective case management
- 3.1.3 Integrate prescription and out of pocket in compliance with ACA regulations.
- 3.1.4 Provide a dedicated full time account executive and manager
- 3.1.5 A renewal notice will be provided at least 120 days prior to each contract anniversary date.
- 3.1.6 Provide claims reporting
- 3.1.7 Provide dedicated account executive/account manager
- 3.1.8 The administrator/vendor will maintain records and information regarding claims filed for a period of time as is deemed appropriate and in accordance with applicable laws. Proposers should also provide monthly claims and utilization reports by the end of the month following the reporting period and quarterly reports within 45 days of the end of the quarter.
- 3.1.9 A designated account management team will be assigned to handle all City of Santa Fe claims. Participation is required in all City of Santa Fe Health Fairs and Open Enrollment Meetings.
- 3.1.10 The City of Santa Fe must be given prior notification of all communication materials sent to City of Santa Fe employees.
- 3.1.11 The administrator/vendor must be able to accept electronic file, record, and transaction formats utilized by the City of Santa Fe. The capability to electronically upload and download data to and from the Proponent's application processing systems without the need to re-key or reformat data is essential.

3.2 Stop Loss Insurance

- 3.2.1 Vendor must provide quote for stop loss insurance matching current ISL and ASL coverage
- 3.2.2 Vendor must provide cost savings alternative quotes

3.3 COBRA Administration

- 3.3.1 Vendor must provide COBRA administration services for the City's entire benefit package which would include medical, dental, and vision.
- 3.3.2 Provide a detailed listing of the services you provide and the associated costs for those services.
- 3.3.3 Provide information on your implementation process

3.3.4 Provide a description of your electronic capabilities

3.4 Flexible Spending Account Administration

3.4.1 Vendors must be able to administer the City's current FSA program including a debit card. If there are any services your organization cannot provide, please explain in detail.

3.4.1.1 Provide complete details of your Administration services.

3.4.1.2 Provide information on your implementation process.

3.4.1.3 Provide a description of your electronic capabilities for both Employer and Employees.

3.4.1.4 Provide information on your reporting capabilities.

3.4.1.5 Describe your quality assurance procedures to ensure the accuracy of data processing and delivery of requested services.

3.5 Wellness Program

3.5.1 Vendor must provide a quote to match current wellness program.

3.5.2 Vendor to also provide full list and details of all wellness components available through the vendor including resources, as well as any cost associated to adding these programs to the current program quoted.

3.5.3 Vendor to provide list of management programs that tie into the medical insurance along with cost associated with providing this type of program (example: Diabetes management).

3.5.4 Provide reporting to show participation and impact of wellness participation.

3.5.5 Provide material on communications used to involve the members as well as materials to keep members engaged.

3.5.6 Provide dedicated account executive/account manager

3.5.7 Participation is required in all City of Santa Fe Health Fairs and Open Enrollment Meetings.

3.5.8 The City of Santa Fe must be given prior notification of all communication materials sent to City of Santa Fe employees.

3.5.9 The administrator/vendor must be able to accept electronic file, record, and transaction formats utilized by the City of Santa Fe. The capability to electronically upload and download data to and from the Proponent's application processing systems without the need to re-key or reformat data is essential.

3.6 Voluntary Vision

3.6.1 Vendor must provide two quotes for voluntary vision insurance matching current coverage in the following two options.

3.6.1.1 Vision coverage is 100% employee paid, not tied to the medical

insurance, but offered by the medical carrier.

3.6.1.2 Vision coverage 100% employee paid, tied to the medical insurance, with an option to option out of the vision coverage.

3.6.2 Provide claims reporting

3.6.3 Provide provider network and disruption report based on zip codes provided in census.

3.6.4 Provide dedicated account executive/account manager

3.6.5 Participation is required in all City of Santa Fe Health Fairs and Open Enrollment Meetings.

3.6.6 The City of Santa Fe must be given prior notification of all communication materials sent to City of Santa Fe employees.

3.6.7 The administrator/vendor must be able to accept electronic file, record, and transaction formats utilized by the City of Santa Fe. The capability to electronically upload and download data to and from the Proponent's application processing systems without the need to re-key or reformat data is essential.

4. General Requirements and Payment of Administrative Fee

4.1 General Requirements

Proposers shall be a recognized administrator licensed to do such business in the State of New Mexico. A copy of the New Mexico license shall be provided by the TPA prior to execution of the Agreement. Proposers shall also have a City of Santa Fe business license and a New Mexico Taxation and Revenue CRS number.

4.2 Payment of Administrative Fees

The City of Santa Fe shall pay the TPA an administrative fee equal to that proposed by the TPA and accepted by City of Santa Fe. Payment shall be made monthly on receipt of an invoice from the TPA. Payment shall be made within forty-five (45) days of receipt of the monthly invoice from the TPA.

The City of Santa Fe is deliberating changes to its plan design(s). Under discussion, among other things, are member eligibility, increases in co-pays; deductibles and/or co-insurance percentages. Proposers should include in their proposal any monetary, service, and/or notables regarding the effect these changes could have on proposers' response.

5. Proposal Response Requirement

5.1 General

Each Proposer shall complete this portion of the Request for Proposals by discussing each item in the order presented. Responses to this Section will be analyzed by City of

Santa Fe to determine the recommendations of the successful Proposer. Responses must be legible, clear, accurate, complete, and must be signed by an authorized representative of the Proposer.

5.2. Title Page

Indicate the name of the firm, the local address, the name of the firm's contact person, the telephone and FAX numbers of the contact person and the date.

5.3 Table of Contents

Include a clear identification of the material submitted by your firm by section and by page number.

5.4 Profile of Firm

- A. State whether your firm is local, regional, national or international. Include information on any affiliations and/or subsidiaries.
- B. State the location of the offices from which the work will be done if your firm is awarded the contract, the number of partners, managers, seniors, supervisors and other professional staff employed by these offices.
- C. Describe the range of activities performed by the offices from which the work will be performed (i.e., insurance sales, administration of other types of programs, general management services.)
- D. Do you accept the delegation of the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with review of claims under the plan?
- E. Do you agree to being appointed named fiduciary under the plan with authority to handle all claim reconsideration requests or appeals of denied ERISA claims?

5.5 Proposers Staffing and Qualifications

- A. Indicate the name of the person who will manage the administration activities as specified in this RFP. Provide a brief resume of the manager's background training and experience. Specifically discuss the individual's experience in managing a claims administration program of the size and scope of the program described herein.
- B. Indicate the names of claims supervisors who will be assigned to City of Santa Fe's program. Include a brief resume of each individual's background training and experience. Indicate whether the supervisors are licensed by the State.
- C. Indicate the number of persons, and identify names and/or association as applicable, certified through the CMS Federally Facilitated Marketplace available to assist individuals seeking health coverage. **In the event that the City of Santa Fe makes changes to its eligibility for enrollment, it will want to have an avenue for the non-covered/non-eligible populations to find assistance in seeking individual health coverage. Adapt your proposal appropriately to indicate how you would provide this service, how the service benefits**

the City of Santa Fe, generally and specifically in assisting our non-covered/non-eligible populations.

5.6 Reports

- A. Describe the various reports related to the program that will be prepared by your firm as part of this proposal, and the frequency thereof. Attach samples of proposed reports.
- B. Will the City or its designee have the ability to access and run reports independently? If yes, please specify the types of reports available from your reporting system.

5.7 Transition Program

Describe the recommended process to be implemented with regard to transition of open claims to a new claims administrator. Include a time frame for implementation of the program from the date of award of contract.

5.8 Record Keeping

Describe record keeping procedures to be utilized for all aspects of the claims administration program.

5.9 Fee / Premium Structure

- A. Describe in detail all fees or premiums to be charged. The fee structure shall be quoted for a four year contract with annual amounts quoted for each year. Annual amounts shall include applicable gross receipts taxes.
- B. Discuss any additional cost for report modifications, specialization, etc.

5.10 Experience of Firm

Discuss experience of your firm relative to administration of claim programs.

- A. Provide the number of self-insured clients for which you currently provide services.
- B. Provide a sample benefit plan description for your Consumer Directed plan(s).
- C. Describe your claim administration process in detail (i.e., auto adjudication capabilities, supervisory level involvement, and service team).
- D. Describe your standard banking arrangements for self-funded clients. Minimum Premium Funding arrangements will be considered.

5.11 PPO Network

- A. What is the name of the network your organization has proposed for the City?
- B. Provide GeoAccess analysis for Primary Care Physicians, Specialists, and Hospitals.
- C. Describe your PPO network contracting arrangements. Is your network leased or owned? Describe any special programs or resources you offer to providers.

- D. Provide your average discounts for the following in the Santa Fe and surrounding NM areas:
- Primary Care Physician and Specialist office visits
 - Inpatient hospitalization
 - Outpatient services
 - Radiology

5.12 Comprehensive Medical Cost Management Services

- A. Describe your company's utilization review, case management, and disease management programs.
- B. Are these programs internally managed by your organization or contracted/outsourced to another company?

5.13 Plan Design

- A. Proposers are required to provide quotes for a triple option made up the current PPO plan, an alternative PPO plan and an HRA plan.
- B. Proposers must quote the above options. Proposers may be disqualified if unable to quote these options. However, in addition to the requested options proposers may suggest changes that may provide the most cost effective benefit solution.
- C. The plan design option specifications are attached.

The City of Santa Fe is deliberating changes to its plan design(s). Under discussion, among other things, are member eligibility, increases in co-pays; deductibles and/or co-insurance percentages. Proposers should include in their proposal any monetary, service, and/or notables regarding the effect these changes could have on proposers' response.

5.14 Personnel / Account Maintenance

The proposer shall list the names of the personnel who will be performing the work for the City and include a copy of their resumes and areas of responsibility they will assume in the overall implementation of this service.

Proposer shall include whether they are certified through CMS Federally Facilitated Marketplace.

The proposer shall identify the number of persons, and identify names and/or association as applicable, certified through the CMS Federally Facilitated Marketplace available to assist individuals seeking health coverage. In the event that the City of Santa Fe makes changes to its eligibility for enrollment, it will want to have an avenue for the non-covered/non-eligible populations to find assistance in seeking individual health coverage.

5.15 Standard Agreement

Include a copy of your firm's standard Agreement covering administration self-insured retention programs. This RFP shall become part of an approved contract as an appendix.

ADDITIONAL REQUIREMENTS

I. POLICY TERMINATION

The agreement may be terminated by either party with or without cause, subject to a 90-day notice.

II. SUBROGATION

Please describe in detail (on a separate sheet) the fee basis for subrogation recovery activities when applicable (percentage of recovery not acceptable).

III. FINANCIAL STATEMENT

Proposers are required to provide current financial statements as part of this proposal.

IV. EXCEPTIONS

Describe in detail services offered which do not meet or exceed the requirements of these specifications (use separate sheet).

V. REFERENCES

Please provide a list of four clients for whom your firm has provided administration services in the past two (2) years.

VI. CLAIMS SERVICE AGREEMENT

Please provide a proposed Third Party Administrator Claims Service Agreement incorporating the terms listed herein for a term of four (4) years beginning July 1, 2015.

**EVALUATION CRITERIA
&
WEIGHTED VALUES**

EVALUATION COMMITTEE MEMBERS

Human Resources Department Director or representative
 City of Santa Fe Group Insurance Advisory Committee Members
 Representative from AON Consulting
 City of Santa Fe Purchasing Director

At its discretion, the City reserves the right to alter the membership and size of the committee. Scores of the evaluation committee members will be totaled to determine the top rated firms.

If interviews are conducted for the top three rated firms, those scores totaled from the evaluation committee members from the interview evaluations will determine the final top rated firm, unless other tangible extenuating circumstances are documented.

Unless noted elsewhere in this RFP, the same evaluation form will be used to separate the interview scores.

SECTION A- MEDICAL INSURANCE ADMINISTRATION

<u>PROPOSAL CRITERIA</u>	Weighted Value	Score 1-5	Evaluation Pts.	Maximum Score
Medical Claims Administration	35% x			175
PPO Network	40% x			200
Medical Cost Management	20% x			100
Dedicated account executive/manager	10% x			50
Pertinent Experience of Vendor and Staff Expertise	10% x			50
Administrative Fees	20% x			100
Wellness Program	20% x			100
FSA Administration	10% x			50
Stop Loss	10% x			50
COBRA	10% x			50
Total				925
Evaluation Points	1-lowest	5-Highest		

SECTION B- VOLUNTARY VISION INSURANCE ADMINISTRATION

<u>PROPOSAL CRITERIA</u>	Weighted Value	Score 1-5	Evaluation Pts.	Maximum Score
Vision Claims Administration Fees	35% x			175
Provider Network	35% x			175
Ease of Eligibility Maintenance	30% x			150
Total				500
Evaluation Points	1-lowest	5-Highest		

INSTRUCTIONS RELATING TO LOCAL PREFERENCE CERTIFICATION FORM

1. **All information must be provided.** A 10% local preference may be available for this procurement. To qualify for this preference, an offeror **must** complete and submit **the local preference certification form with its offer**. If an offer is received without the form attached, completed, notarized, and signed or if the form is received without the required information, the preference will not be applied. **The local preference form or a corrected form will not be accepted after the deadline for receipt of bids or proposals.**
2. **Local Preference precedence over State Preference:** The Local Preference takes precedence over the State Resident Preference and only one such preference will be applied to any one bid or proposal. If it is determined that the local preference applies to one or more offerors in any solicitation, the State Resident Preference will not be applied to any offers.
3. **Principal Office and location must be stated:** To qualify for the local preference, the principal place of business of the enterprise must be physically located within the Santa Fe County Geographic Boundaries. The business location inserted on the Form must be a physical location, street address or such. **DO NOT** use a post office box or other postal address. Principal place of business must have been established no less than six months preceding application for certification.
4. **Subcontractors do not qualify:** Only the business, or if joint venture, one of the parties of the joint venture, which will actually be performing the services or providing the goods solicited by this request and will be responsible under any resulting contract will qualify for this preference. A subcontractor may not qualify on behalf of a prime contractor.
5. **Definition:** The following definition applies to this preference.

A local business is an entity with its Principal office and place of business located in Santa Fe County.

A Principal office is defined as: The main or home office of the business as identified in tax returns, business licenses and other official business documents. A Principal office is the primary location where the business conducts its daily operations, for the general public, if applicable. A temporary location or movable property, or one that is established to oversee a City of Santa Fe project does not qualify as a Principal office.

Additional Documentation: If requested a business will be required to provide, within 3 working days of the request, documentation to substantiate the information provided on the form. Any business which must be registered under state law must be able to show that it is a business entity in good standing if so requested.

LOCAL PREFERENCE CERTIFICATION FORM

RFP/RFB NO: _____

Business Name: _____

Principal Office: _____
Street Address City State Zip Code

City of Santa Fe Business License # _____ (Attach Copy to this Form)

Date Principal Office was established: _____ (Established date must be six months before date of Publication of this RFP or RFB).

CERTIFICATION

I hereby certify that the business set out above is the principal Offeror submitting this offer or is one of the principal Offerors jointly submitting this offer (e.g. as a partnership, joint venture). I hereby certify that the information which I have provided on this Form is true and correct, that I am authorized to sign on behalf of the business set out above and, if requested by the City of Santa Fe, will provide within 3 working days of receipt of notice, the necessary documents to substantiate the information provided on this Form.

Signature of Authorized Individual: _____

Printed Name: _____

Title: _____ Date: _____

Subscribed and sworn before me by _____ this _____, day of _____

My commission expires _____

Notary Public

SEAL

YOU MUST RETURN THIS FORM WITH YOU OFFER

RESIDENT VETERANS PREFERENCE CERTIFICATION

_____ (NAME OF CONTRACTOR) hereby certifies the following in regard to application of the resident veterans' preference to this procurement.

Please check one box only:

I declare under penalty of perjury that my business prior year revenue starting January 1 ending December 31 is less than \$1M allowing me the 10% preference discount on this solicitation. I understand that knowingly giving false or misleading information about this fact constitutes a crime.

I declare under penalty of perjury that my business prior year revenue starting January 1 ending December 31 is more than \$1M but less than \$5M allowing me the 8% preference discount on this solicitation. I understand that knowingly giving false or misleading information about this fact constitutes a crime.

I declare under penalty of perjury that my business prior year revenue starting January 1 ending December 31 is more than \$5M allowing me the 7% preference discount on this solicitation. I understand that knowingly giving false or misleading information about this fact constitutes a crime.

I agree to submit a report or reports to the State Purchasing Division of the General Services Department declaring under penalty of perjury that during the last calendar year starting January 1 and ending on December 31, the following to be true and accurate:

In conjunction with this procurement and the requirements of this business application for a Resident Veteran Business Preference/Resident Veteran Contractor Preference under Sections 13-1-21 or 13-1-22 NMSA 1978, which awarded a contract which was on the basis of having such veterans preference, I agree to report to the State Purchasing Division of the General Services Department the awarded amount involved. I will indicate in the report the award amount as a purchase from a public body or as a public works contract from a public body as the case may be.

I understand that knowingly giving false or misleading information on this report constitutes a crime.

I declare under penalty of perjury that this statement is true to the best of my knowledge. I understand that giving false or misleading statements about material fact regarding this matter constitutes a crime.

(Signature of Business Representative)*

(Date)

*Must be an authorized signatory of the Business.

The representation made by checking the above boxes constitutes a material representation by the business. If the statements are proven to be incorrect, this may result in denial of an award or un-award of the procurement.

SIGNED AND SEALED THIS _____ DAY OF _____, 2012.

NOTARY PUBLIC

My Commission Expires:

MEDICAL PSA SAMPLE FOR RFP

REQUEST FOR PROPOSALS
CITY OF SANTA FE
PROFESSIONAL SERVICES AGREEMENT

THIS AGREEMENT is made and entered into by and between the City of Santa Fe (the "City") and _____ (the "Contractor"). The date of this Agreement shall be the date when it is executed by the City and the Contractor, whichever occurs last.

1. SCOPE OF SERVICES

The Contractor shall provide the following services for the City:

A. Medical TPA Services

- (1) Administer requested plan designs – premium, core and value HRA
- (2) Provide effective case management
- (3) Integrate prescription and out of pocket in compliance with ACA regulations.
- (4) Provide a dedicated full time account executive and manager
- (5) A renewal notice will be provided at least 120 days prior to each contract anniversary date.
- (6) Provide claims reporting
- (7) Provide dedicated account executive/account manager
- (8) The administrator/vendor will maintain records and information regarding claims filed for a period of time as is deemed appropriate and in accordance with applicable laws. Proposers should also provide monthly claims and utilization reports by the end of the month following the reporting period and quarterly reports within 45 days of the end of the quarter.
- (9) A designated account management team will be assigned to handle all City of Santa Fe claims. Participation is required in all City of Santa Fe Health Fairs and Open Enrollment Meetings.

- (10) The City of Santa Fe must be given prior notification of all communication materials sent to City of Santa Fe employees.
- (11) The administrator/vendor must be able to accept electronic file, record, and transaction formats utilized by the City of Santa Fe. The capability to electronically upload and download data to and from the Proponent's application processing systems without the need to re-key or reformat data is essential.

B. Stop Loss Insurance

Vendor must provide quote for stop loss insurance matching current ISL and ASL coverage. Vendor must provide cost savings alternative Quotes.

C. COBRA Administration

Vendor must provide COBRA administration services for the City's entire benefit package which would include medical, dental, and vision.

D. Flexible Spending Account Administration

Vendors must be able to administer the City's current FSA program including a debit card. Any services not provided are listed in detail.

E. Wellness Program

- (1) Vendor must provide a current wellness program with a full list and details of all wellness components available through the vendor including resources, as well as any cost associated to adding these programs to the current program quoted.
- (2) Vendor to provide list of management programs that tie into the medical insurance along with cost associated with providing this type of program (example: Diabetes management).
- (3) Vendor must provide reporting to show participation and impact of wellness participation.
- (4) Vendor must provide material on communications used to involve the members as well as materials to keep members engaged.
- (5) Vendor must provide dedicated account executive/account manager.

- (6) Participation is required in all City of Santa Fe Health Fairs and Open Enrollment Meetings.
- (7) The City of Santa Fe must be given prior notification of all communication materials sent to City of Santa Fe employees.
- (8) The administrator/vendor must be able to accept electronic file, record, and transaction formats utilized by the City of Santa Fe. The capability to electronically upload and download data to and from the Proponent's application processing systems without the need to re-key or reformat data is essential.

F. Voluntary Vision

Vendor must provide two quotes for voluntary vision insurance matching current coverage in the following two options.

- (1) Vision coverage is 100% employee paid, not tied to the medical insurance, but offered by the medical carrier.
- (2) Vision coverage 100% employee paid, tied to the medical insurance, with an option to option out of the vision coverage.

G. Provide claims reporting

H. Provide provider network and disruption report based on zip codes provided in census.

I. Provide dedicated account executive/account manager

J. Participation is required in all City of Santa Fe Health Fairs and Open Enrollment Meetings.

K. The City of Santa Fe must be given prior notification of all communication materials sent to City of Santa Fe employees.

L. The administrator/vendor must be able to accept electronic file, record, and transaction formats utilized by the City of Santa Fe. The capability to electronically upload and download data to and from the Proponent's application processing systems without the need to re-key or reformat data is essential.

2. STANDARD OF PERFORMANCE; LICENSES

A. The Contractor represents that it possesses the experience and knowledge necessary to perform the services described under this Agreement.

B. The Contractor agrees to obtain and maintain throughout the term of this Agreement, all applicable professional and business licenses required by law, for itself, its employees, agents, representatives and subcontractors.

3. COMPENSATION

A. The City shall pay to the Contractor in full payment for services rendered, a sum not to exceed _____dollars (\$_____),plus/ inclusive of applicable gross receipts taxes. , Payment shall be made for services actually rendered at a rate of _____ dollars (\$_____) per hour.

B. The Contractor shall be responsible for payment of gross receipts taxes levied by the State of New Mexico on the sums paid under this Agreement.

C. Payment shall be made upon receipt, approval and acceptance by the City of detailed statements containing a report of services completed. Compensation shall be paid only for services actually performed and accepted by the City.

4. APPROPRIATIONS

The terms of this Agreement are contingent upon sufficient appropriations and authorization being made by the City for the performance of this Agreement. If sufficient appropriations and authorization are not made by the City, this Agreement shall terminate upon written notice being given by the City to the Contractor. The City's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final.

5. TERM AND EFFECTIVE DATE

This Agreement shall be effective when signed by the City and the Contractor, whichever occurs last, and shall terminate on _____ unless sooner pursuant to Article 6 below.

6. TERMINATION

A. This Agreement may be terminated by the City upon 30 days written notice to the Contractor.

(1) The Contractor shall render a final report of the services performed up to the date of termination and shall turn over to the City original copies of all work product, research or papers prepared under this Agreement.

(2) If compensation is not based upon hourly rates for services rendered, therefore the City shall pay the Contractor for the reasonable value of services satisfactorily performed through the date Contractor receives notice of such termination, and for which compensation has not already been paid.

(3) If compensation is based upon hourly rates and expenses, Contractor shall be paid for services rendered and expenses incurred through the date Contractor receives notice of such termination.

7. STATUS OF CONTRACTOR; RESPONSIBILITY FOR PAYMENT OF EMPLOYEES AND SUBCONTRACTORS

A. The Contractor and its agents and employees are independent contractors performing professional services for the City and are not employees of the City. The Contractor, and its agents and employees, shall not accrue leave, retirement,

insurance, bonding, use of City vehicles, or any other benefits afforded to employees of the City as a result of this Agreement.

B. Contractor shall be solely responsible for payment of wages, salaries and benefits to any and all employees or subcontractors retained by Contractor in the performance of the services under this Agreement.

C. The Contractor shall comply with City of Santa Fe Minimum Wage, Article 28-1-SFCC 1987, as well as any subsequent changes to such article throughout the term of this Agreement.

8. CONFIDENTIALITY

Any confidential information provided to or developed by the Contractor in the performance of this Agreement shall be kept confidential and shall not be made available to any individual or organization by the Contractor without the prior written approval of the City.

9. CONFLICT OF INTEREST

The Contractor warrants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required under this Agreement. Contractor further agrees that in the performance of this Agreement no persons having any such interests shall be employed.

10. ASSIGNMENT; SUBCONTRACTING

The Contractor shall not assign or transfer any rights, privileges, obligations or other interest under this Agreement, including any claims for money due, without the prior written consent of the City. The Contractor shall not subcontract any portion of the

services to be performed under this Agreement without the prior written approval of the City.

11. RELEASE

The Contractor, upon acceptance of final payment of the amount due under this Agreement, releases the City, its officers and employees, from all liabilities, claims and obligations whatsoever arising from or under this Agreement. The Contractor agrees not to purport to bind the City to any obligation not assumed herein by the City unless the Contractor has express written authority to do so, and then only within the strict limits of that authority.

12. INSURANCE

A. The Contractor, at its own cost and expense, shall carry and maintain in full force and effect during the term of this Agreement, comprehensive general liability insurance covering bodily injury and property damage liability, in a form and with an insurance company acceptable to the City, with limits of coverage in the maximum amount which the City could be held liable under the New Mexico Tort Claims Act for each person injured and for each accident resulting in damage to property. Such insurance shall provide that the City is named as an additional insured and that the City is notified no less than 30 days in advance of cancellation for any reason. The Contractor shall furnish the City with a copy of a Certificate of Insurance as a condition prior to performing services under this Agreement.

B. Contractor shall also obtain and maintain Workers' Compensation insurance, required by law, to provide coverage for Contractor's employees throughout

the term of this Agreement. Contractor shall provide the City with evidence of its compliance with such requirement.

C. Contractor shall maintain professional liability insurance throughout the term of this Agreement providing a minimum coverage in the amount required under the New Mexico Tort Claims Act. The Contractor shall furnish the City with proof of insurance of Contractor's compliance with the provisions of this section as a condition prior to performing services under this Agreement.

13. INDEMNIFICATION

The Contractor shall indemnify, hold harmless and defend the City from all losses, damages, claims or judgments, including payments of all attorneys' fees and costs on account of any suit, judgment, execution, claim, action or demand whatsoever arising from Contractor's performance under this Agreement as well as the performance of Contractor's employees, agents, representatives and subcontractors.

14. NEW MEXICO TORT CLAIMS ACT

Any liability incurred by the City of Santa Fe in connection with this Agreement is subject to the immunities and limitations of the New Mexico Tort Claims Act, Section 41-4-1, et. seq. NMSA 1978, as amended. The City and its "public employees" as defined in the New Mexico Tort Claims Act, do not waive sovereign immunity, do not waive any defense and do not waive any limitation of liability pursuant to law. No provision in this Agreement modifies or waives any provision of the New Mexico Tort Claims Act.

15. THIRD PARTY BENEFICIARIES

By entering into this Agreement, the parties do not intend to create any right, title or interest in or for the benefit of any person other than the City and the

Contractor. No person shall claim any right, title or interest under this Agreement or seek to enforce this Agreement as a third party beneficiary of this Agreement.

16. RECORDS AND AUDIT

The Contractor shall maintain, throughout the term of this Agreement and for a period of three years thereafter, detailed records that indicate the date, time and nature of services rendered. These records shall be subject to inspection by the City, the Department of Finance and Administration, and the State Auditor. The City shall have the right to audit the billing both before and after payment. Payment under this Agreement shall not foreclose the right of the City to recover excessive or illegal payments.

17. APPLICABLE LAW; CHOICE OF LAW; VENUE

Contractor shall abide by all applicable federal and state laws and regulations, and all ordinances, rules and regulations of the City of Santa Fe. In any action, suit or legal dispute arising from this Agreement, the Contractor agrees that the laws of the State of New Mexico shall govern. The parties agree that any action or suit arising from this Agreement shall be commenced in a federal or state court of competent jurisdiction in New Mexico. Any action or suit commenced in the courts of the State of New Mexico shall be brought in the First Judicial District Court.

18. AMENDMENT

This Agreement shall not be altered, changed or modified except by an amendment in writing executed by the parties hereto.

19. SCOPE OF AGREEMENT

This Agreement incorporates all the agreements, covenants, and understandings between the parties hereto concerning the services to be performed hereunder, and all such agreements, covenants and understandings have been merged into this Agreement. This Agreement expresses the entire Agreement and understanding between the parties with respect to said services. No prior agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

20. NON-DISCRIMINATION

During the term of this Agreement, Contractor shall not discriminate against any employee or applicant for an employment position to be used in the performance of services by Contractor hereunder, on the basis of ethnicity, race, age, religion, creed, color, national origin, ancestry, sex, gender, sexual orientation, physical or mental disability, medical condition, or citizenship status.

21. SEVERABILITY

In case any one or more of the provisions contained in this Agreement or any application thereof shall be invalid, illegal or unenforceable in any respect, the validity, legality, and enforceability of the remaining provisions contained herein and any other application thereof shall not in any way be affected or impaired thereby.

22. NOTICES

Any notices required to be given under this Agreement shall be in writing and served by personal delivery or by mail, postage prepaid, to the parties at the following addresses:

City of Santa Fe:

Contractor:

IN WITNESS WHEREOF, the parties have executed this Agreement on the date set forth below.

CITY OF SANTA FE:

CONTRACTOR:

BRIAN K. SNYDER,
CITY MANAGER
or
JAVIER M. GONZALES, MAYOR

NAME AND TITLE

DATE: _____

DATE: _____

CRS# _____
City of Santa Fe Business
Registration # _____

ATTEST:

YOLANDA Y. VIGIL
CITY CLERK

APPROVED AS TO FORM:

KELLEY A. BRENNAN, CITY ATTORNEY

APPROVED:

OSCAR RODRIGUEZ, FINANCE DIRECTOR

IN WITNESS WHEREOF, the parties have executed this Agreement on the date set forth below.

CITY OF SANTA FE:

CONTRACTOR:

BRIAN K. SNYDER,
CITY MANAGER
or
JAVIER M. GONZALES, MAYOR

NAME AND TITLE

DATE: _____

DATE: _____

CRS# _____
City of Santa Fe Business
Registration # _____

ATTEST:

YOLANDA Y. VIGIL
CITY CLERK

APPROVED AS TO FORM:

MDA/ 1/6/15
KELLEY A. BRENNAN, CITY ATTORNEY

APPROVED:

OSCAR RODRIGUEZ, FINANCE DIRECTOR

Business Unit Line Item

Living Wage Ordinance

Ordinance Number §28-1-28-1.12DSFCC 1987

Purpose:

The City of Santa Fe Living Wage Ordinance was adopted to establish minimum hourly wages.

Who it affects:

- All profit and nonprofit businesses required to have a business license or business registration with the City of Santa Fe.

Compliance:

- Affected businesses are required to pay employees an hourly wage of \$10.66 effective March 1, 2014.
- Beginning January 1, 2009, and each year thereafter, the minimum wage shall be adjusted upward by an amount corresponding to the previous year's increase, if any, in the Consumer Price Index for the Western Region for Urban Wage Earners and Clerical Workers.
- For workers who customarily receive more than \$100 per month in tips or commissions, any tips or commissions received and retained by a worker shall be counted as wages and credited toward satisfaction of the minimum wage provided that, for tipped workers, all tips received by such workers are retained by the workers, except that the pooling of tips among workers shall be permitted.
- The value of health care benefits and child care shall be considered as an element of wages.
- Nonprofit organizations whose primary source of funds is from Medicaid waivers are *exempt*.

Prohibitions against retaliation and circumvention:

- It shall be unlawful for any business, employer or employer's agent or representative to take any action against an individual in retaliation for exercising or communicating rights under this ordinance. This includes retaliation against individuals who mistakenly but in good faith allege noncompliance with the ordinance.
- Taking adverse action against an individual within 60 days of the individual's assertion of or communication of information regarding rights raises a reputable presumption of retaliation for assertion of rights.
- It shall be unlawful for any business or employer to intentionally circumvent the requirements of this ordinance by contracting portions of its operations or leasing portions of its property.

Enforcement and Remedies:

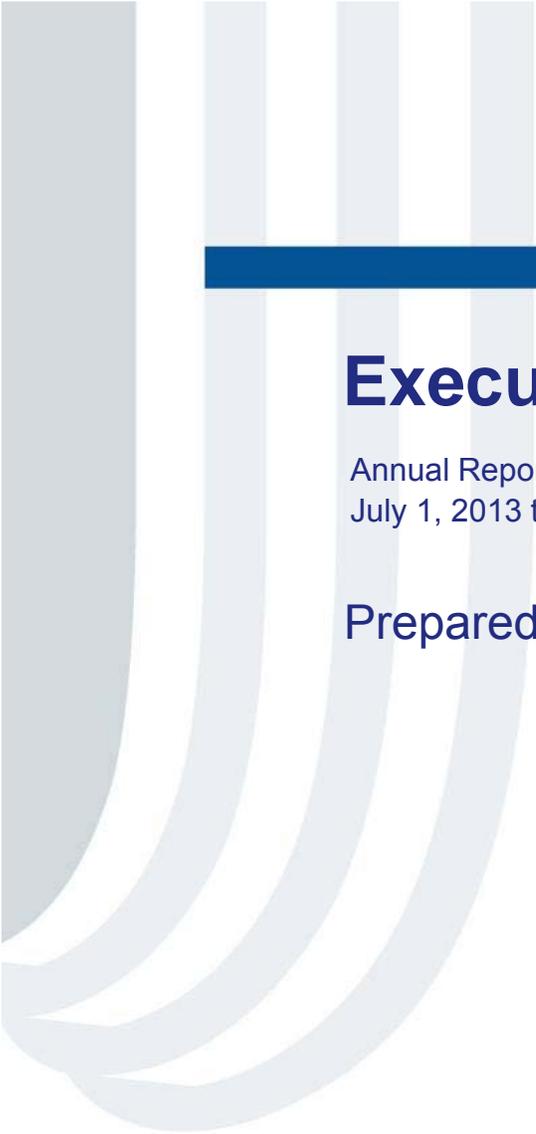
- Administrative Enforcement—The city manager, or his/her designee, is authorized, as appropriate and as resources permit, to enforce this ordinance.
- Criminal Penalty—A person violating this ordinance shall be guilty of a misdemeanor and, upon conviction, for each offense may be subject to fines and imprisonment as set forth in Section 1-3 SFCC 1987. A person violating any of the requirements of this ordinance shall be guilty of a separate offense for each day or portion thereof and for each worker or person to whom any such violation occurred.
- Other Remedies—The city, any individual aggrieved by a violation of this ordinance, or any entity the members of which have been aggrieved by a violation of this ordinance, may bring a civil action in a court of competent jurisdiction to restrain, correct, abate or remedy any violation of this ordinance and, upon prevailing, shall be entitled to such legal or equitable relief as may be appropriate to remedy the violation including, without limitation, reinstatement, the payment of any wages due and an additional amount as liquidated damages equal to twice the amount of any wages due, injunctive relief, and reasonable attorney's fees and costs.

Nonexclusive Remedies and Penalties—The remedies provided in this section are not exclusive, and nothing in this ordinance shall preclude any person from seeking any other remedies, penalties, or relief provided by law.

Posting and Publication:

- Any business subject to the provisions of this ordinance shall as a condition to obtaining and holding a City of Santa Fe business license or registration, post and display in a prominent location next to its business license or registration on the business premises a notice, in English and Spanish, that the business is in compliance with the provisions of this ordinance and post the text of this notice. Failure to comply with this section shall be construed a violation of this ordinance and, in addition, shall be considered grounds for suspensions, revocation, or termination of the business license or registration.

For more information, please contact: Constituent Services at 505-955-6949 Email: constituentservices@santafenm.gov



Executive Performance Report

Annual Report of Healthplan Performance
July 1, 2013 through June 30, 2014

Prepared for CITY OF SANTA FE

Table of Contents

CITY OF SANTA FE

The information contained in this report includes current and prior period experience as well as relevant normative data. Norms are based on the average experience for the Public Sector Industry and have not been adjusted for the characteristics of your covered population, except where noted otherwise. The following parameters apply:

- Claim experience is 96.3% complete and has not been adjusted to estimate full completion.
- Available data for Medicare primary members is not included.
- Available data for pharmacy is included but is not rolled into total net payment amounts.
- Available data for mental health and substance abuse is included.
- The high cost threshold is \$50,000. 'Non-High Cost' excludes all medical payments for high cost claimants.

Current Period: Incurred July 1, 2013 through June 30, 2014, paid July 1, 2013 through September 30, 2014

Prior Period: Incurred July 1, 2012 through June 30, 2013, paid July 1, 2012 through September 30, 2013

Overview

Key Performance Indicators page 3

Performance Report

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Inpatient Hospital Admissions page 15

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Appendix

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Overview

Key Performance Indicators

CITY OF SANTA FE

Current Period: Incurred July 1, 2013 through June 30, 2014, paid July 1, 2013 through September 30, 2014

Prior Period: Incurred July 1, 2012 through June 30, 2013, paid July 1, 2012 through September 30, 2013

Financial Summary	Prior	Current	Change	Public Sector	Variance
Medical Covered Expenses	\$13,927,732	\$14,955,956	7.4%	-	-
Medical Covered Expenses PMPM	\$369.16	\$395.79	7.2%	\$407.27	-2.8%
Non-High Cost	\$285.20	\$278.75	-2.3%	\$271.57	2.6%
High Cost	\$83.96	\$117.04	39.4%	\$135.71	-13.8%
Pharmacy Covered PMPM	\$63.30	\$63.55	0.4%	\$98.87	-35.7%
Medical Net Paid	\$13,066,559	\$14,329,261	9.7%	-	-
Medical Net Paid PMPM	\$346.34	\$379.20	9.5%	\$359.36	5.5%
Non-High Cost	\$263.26	\$263.57	0.1%	\$235.43	12.0%
High Cost	\$83.07	\$115.63	39.2%	\$123.93	-6.7%
Pharmacy Net Paid PMPM	\$55.50	\$56.32	1.5%	\$83.60	-32.6%
HRA Payments *	\$14,335	\$15,335	7.0%	-	-
HRA Payments PMPM	\$0.38	\$0.41	6.8%	-	-
Medical	\$0.38	\$0.41	6.8%	-	-
Pharmacy	\$0.00	\$0.00	0.0%	-	-
Medical Plan Enrollment	Prior	Current	Change	Public Sector	Variance
Enrolled Employees	1,240	1,237	-0.2%	-	-
Enrolled Members	3,144	3,149	0.2%	-	-
Average Family Size	2.54	2.55	0.4%	2.20	15.8%
Average Member Age	31.5	31.4	-0.3%	-	-
% Female Members	47.2%	47.2%	0.0	52.2%	-5.0
Age / Gender Factor	0.960	0.959	-0.1%	1.149	-16.5%
Members Utilizing Medical Benefits	94.4%	96.2%	1.8	-	-
High Cost Claimants per 1,000	8.27	13.02	57.4%	12.37	5.3%
Cost Management	Prior	Current	Change	Public Sector	Variance
Gross Benefit Adequacy	96.1%	96.6%	0.5	90.9%	5.7
Network Utilization	96.6%	98.0%	1.4	95.8%	2.2
Network Discounts	\$9,026,629	\$9,269,576	2.7%	-	-
Network Discounts PMPM	\$239.26	\$245.30	2.5%	-	-
Network Discount Percent	41.9%	40.0%	-2.0	-	-
Inpatient Hospital Admissions	Prior	Current	Change	Public Sector	Variance
Admissions per 1,000	50.3	47.6	-5.2%	55.5	-14.2%
Days per 1,000	192.7	203.6	5.6%	267.7	-23.9%
Average Length of Stay	3.84	4.27	11.4%	4.82	-11.4%
Average Net Paid per Admission	\$13,320	\$19,047	43.0%	\$19,003	0.2%
Outpatient Cost and Utilization	Prior	Current	Change	Public Sector	Variance
Outpatient Surgeries per 1,000	132.0	128.0	-3.0%	159.0	-19.5%
Net Paid per Surgery	\$3,267	\$4,144	26.9%	\$3,296	25.7%
Emergency Room Visits per 1,000	208.7	188.6	-9.6%	207.5	-9.1%
Net Paid per Emergency Room per Visit	\$1,552	\$1,578	1.7%	\$1,154	36.8%
Primary Physician Visits PMPY	1.95	1.98	1.3%	2.07	-4.7%
Specialist Visits PMPY (incl OB/Gyn)	1.48	1.39	-5.8%	1.93	-28.1%
Net Paid per Primary Physician Visit	\$109.53	\$111.01	1.4%	\$82.14	35.1%
Net Paid per Specialist Visit (incl OB/Gyn)	\$155.14	\$159.58	2.9%	\$114.59	39.3%
Common Diagnosis (Claimants per 1,000)	Prior	Current	Change	Public Sector	Variance
Diabetes without complications	48.0	57.5	19.7%	70.2	-18.1%
Diabetes with complications	21.6	18.1	-16.3%	30.6	-40.8%
Hypertension	57.3	54.6	-4.6%	120.6	-54.7%
Acute Myocardial Infarction	1.3	1.6	24.8%	1.5	3.8%
Coronary Atherosclerosis	6.4	6.0	-5.2%	19.2	-68.6%
Congestive Heart Failure (CHF)	2.2	2.5	14.1%	3.5	-27.1%
Chronic Renal Failure	1.3	3.2	149.6%	6.7	-52.4%
Chronic Obstructive Pulmonary Disease	18.4	24.8	34.3%	19.2	28.8%
Asthma	37.2	38.4	3.3%	35.7	7.5%
Intervertebral Disc Disorders	271.0	280.1	3.4%	124.9	124.3%
Normal Pregnancy/Delivery	27.0	27.0	-0.2%	24.2	11.4%
Depression	42.9	48.3	12.4%	45.3	6.5%
Breast Cancer	3.5	3.2	-9.2%	8.8	-63.8%
Cervical Cancer	6.0	6.7	10.4%	6.0	10.6%
Colon Cancer	1.0	1.6	66.4%	1.5	3.8%
Rheumatoid Arthritis	6.0	7.0	15.6%	7.1	-1.7%
Multiple Sclerosis	1.9	1.6	-16.8%	2.2	-27.2%
Enteritis/Ulcerative Colitis	3.2	2.5	-20.1%	4.8	-46.6%

Performance Report

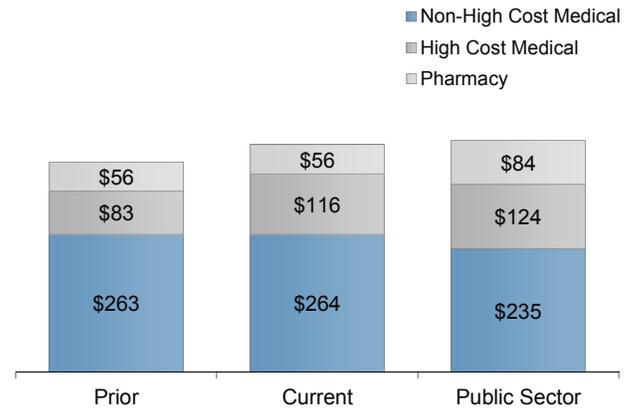
Financial Summary

Net Paid PMPM trend (excluding pharmacy) is at 9.5%, driven in part by a 57.4% increase in high cost claimants per 1,000.

Net Paid PMPM Cost Comparison

This report includes an integrated assessment of healthplan performance, highlights changes that impacted trend and presents variances from Industry comparators. The data included in this package is intended to provide insight to drive program enhancements, benefit plan changes and other strategic actions directed at improving both the quality and the affordability of the overall health care experience.

Net Paid PMPM trend (excluding pharmacy) is at 9.5%. Primary contributors to this trend are a 57.4% increase in high cost claimants per 1,000 and a 7.4% increase in net paid per claimant.



Summary of Results <i>(includes pharmacy)</i>	Prior	Current	Change	Public Sector	Variance
Enrolled Members	3,144	3,149	0.2%	-	-
Covered Expenses	\$16,315,999	\$17,357,395	6.4%	-	-
Covered Expenses PMPM	\$432.46	\$459.34	6.2%	\$506.15	-9.2%
Net Paid	\$15,160,468	\$16,457,586	8.6%	-	-
Net Paid PMPM	\$401.84	\$435.52	8.4%	\$442.96	-1.7%

Components of Cost	Prior	Current	Change	Public Sector	Variance
Medical Net Paid PMPM	\$346.34	\$379.20	9.5%	\$359.36	5.5%
Non-High Cost	\$263.26	\$263.57	0.1%	\$235.43	12.0%
High Cost	\$83.07	\$115.63	39.2%	\$123.93	-6.7%
Pharmacy Net Paid PMPM	\$55.50	\$56.32	1.5%	\$83.60	-32.6%
HRA Payments PMPM *	\$0.38	\$0.41	6.8%	-	-

* HRA Payments are included in the Medical and Pharmacy Components of Cost

Medical Cost Comparison

Comparator	PMPM	Variance
Consumer Directed Average	\$280.05	35.4%
National Average	\$324.05	17.0%
Market Weighted Average	\$328.86	15.3%
Industry Peers	\$359.36	5.5%
CITY OF SANTA FE	\$379.20	0.0%

Comparing results to a range of averages can provide valuable insights to benefit plan performance. In general, groups with a higher level of management of health care services and a higher adoption of cost control initiatives will experience lower overall costs. Norms are based on the average experience for the Public Sector Industry and have not been adjusted for the characteristics of your covered population, except where noted otherwise. The Consumer Directed norm is a group average and has not been adjusted.

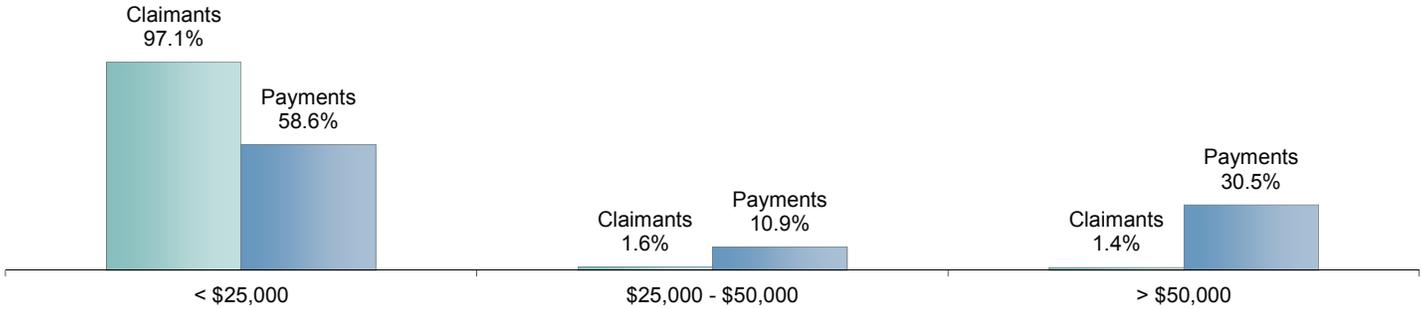
Financial Summary

Distribution by Size of Medical Payment

Those with more than \$50,000 in net payments represent 1.4% of all claimants and 30.5% of total medical costs.

We can identify shifts in utilization, health care consumption and the prevalence of chronic and high cost claimants by looking at the distribution of cost and utilization by fixed payment bands. This breakdown may also be useful for investigating the number of claimants that would be impacted by the introduction of or changes to a consumer-driven, high-deductible benefit.

Medical Claimants and Payments by Range



Medical Payment Range	Claimants per 1,000			% of Total		Net Paid PMPM			% of Total		Net Paid per Claimant			Contribution to Trend Points
	Prior	Current	Change	Prior	Current	Prior	Current	Change	Prior	Current	Prior	Current	Change	
- \$0	3.8	3.5	-8.5%	0.4%	0.4%	\$0.00	\$0.00	0.0%	0.0%	0.0%	\$0	\$0	0.0%	0.0
\$0 - \$50	9.5	13.7	43.1%	1.0%	1.4%	\$0.02	\$0.04	58.7%	0.0%	0.0%	\$29	\$32	10.9%	0.0
\$50 - \$100	26.7	32.1	20.0%	2.8%	3.3%	\$0.18	\$0.22	18.8%	0.1%	0.1%	\$82	\$81	-1.0%	0.0
\$100 - \$150	40.7	49.5	21.7%	4.3%	5.2%	\$0.43	\$0.52	21.4%	0.1%	0.1%	\$127	\$127	-0.2%	0.0
\$150 - \$200	30.9	38.4	24.5%	3.3%	4.0%	\$0.44	\$0.56	25.2%	0.1%	0.1%	\$173	\$174	0.6%	0.0
\$200 - \$250	32.8	33.7	2.7%	3.5%	3.5%	\$0.61	\$0.62	3.0%	0.2%	0.2%	\$222	\$223	0.2%	0.0
\$250 - \$300	31.5	39.4	25.1%	3.3%	4.1%	\$0.72	\$0.91	26.4%	0.2%	0.2%	\$274	\$276	1.1%	0.1
\$300 - \$350	30.9	21.0	-32.1%	3.3%	2.2%	\$0.83	\$0.57	-31.6%	0.2%	0.2%	\$325	\$327	0.6%	-0.1
\$350 - \$400	26.7	21.6	-19.2%	2.8%	2.2%	\$0.83	\$0.67	-19.4%	0.2%	0.2%	\$374	\$373	-0.2%	0.0
\$400 - \$450	20.4	25.1	23.2%	2.2%	2.6%	\$0.71	\$0.88	23.5%	0.2%	0.2%	\$421	\$422	0.2%	0.0
\$450 - \$500	22.3	21.0	-5.9%	2.4%	2.2%	\$0.88	\$0.83	-5.1%	0.3%	0.2%	\$474	\$478	0.8%	0.0
\$500 - \$2,000	295.5	295.0	-0.2%	31.3%	30.7%	\$26.68	\$26.52	-0.6%	7.7%	7.0%	\$1,083	\$1,079	-0.5%	0.0
\$2,000 - \$5,000	177.5	172.4	-2.8%	18.8%	17.9%	\$47.53	\$45.64	-4.0%	13.7%	12.0%	\$3,214	\$3,176	-1.2%	-0.5
\$5,000 - \$10,000	108.5	99.1	-8.6%	11.5%	10.3%	\$62.29	\$57.90	-7.0%	18.0%	15.3%	\$6,892	\$7,012	1.8%	-1.3
\$10,000 - \$15,000	35.6	37.5	5.2%	3.8%	3.9%	\$36.43	\$37.51	3.0%	10.5%	9.9%	\$12,270	\$12,011	-2.1%	0.3
\$15,000 - \$25,000	27.7	30.8	11.3%	2.9%	3.2%	\$44.01	\$48.71	10.7%	12.7%	12.8%	\$19,087	\$18,975	-0.6%	1.4
\$25,000 - \$35,000	9.5	10.5	9.8%	1.0%	1.1%	\$23.27	\$25.01	7.5%	6.7%	6.6%	\$29,260	\$28,643	-2.1%	0.5
\$35,000 - \$50,000	5.1	4.8	-6.4%	0.5%	0.5%	\$17.39	\$16.46	-5.3%	5.0%	4.3%	\$40,996	\$41,478	1.2%	-0.3
\$50,000 - \$100,000	5.1	7.3	43.5%	0.5%	0.8%	\$28.91	\$40.95	41.7%	8.3%	10.8%	\$68,165	\$67,283	-1.3%	3.5
\$100,000 - \$150,000	1.3	2.5	99.7%	0.1%	0.3%	\$13.61	\$25.95	90.6%	3.9%	6.8%	\$128,413	\$122,560	-4.6%	3.6
\$150,000 - \$200,000	1.0	2.5	166.2%	0.1%	0.3%	\$14.22	\$36.36	155.7%	4.1%	9.6%	\$178,833	\$171,763	-4.0%	6.4
\$200,000 - \$250,000	0.6	0.3	-50.1%	0.1%	0.0%	\$11.86	\$5.63	-52.5%	3.4%	1.5%	\$223,765	\$212,835	-4.9%	-1.8
\$250,000 +	0.3	0.3	-0.2%	0.0%	0.0%	\$14.47	\$6.74	-53.4%	4.2%	1.8%	\$545,872	\$254,531	-53.4%	-2.2
Total Medical	943.7	961.9	1.9%	100.0%	100.0%	\$346.34	\$379.20	9.5%	100.0%	100.0%	\$4,404	\$4,731	7.4%	9.5

Subtotals	Prior	Current	Change	Prior	Current	Prior	Current	Change	Prior	Current	Prior	Current	Change	Points
- \$0	3.8	3.5	-8.5%	0.4%	0.4%	\$0.00	\$0.00	0.0%	0.0%	0.0%	\$0	\$0	0.0%	0.0
\$0 - \$25,000	917.0	930.1	1.4%	97.2%	96.7%	\$222.61	\$222.09	-0.2%	64.3%	58.6%	\$2,913	\$2,865	-1.6%	-0.1
\$25,000 - \$50,000	14.6	15.2	4.2%	1.6%	1.6%	\$40.65	\$41.48	2.0%	11.7%	10.9%	\$33,342	\$32,654	-2.1%	0.2
\$50,000 +	8.3	13.0	57.4%	0.9%	1.4%	\$83.07	\$115.63	39.2%	24.0%	30.5%	\$120,546	\$106,572	-11.6%	9.4
Total Excluding \$0	939.9	958.4	2.0%	99.6%	99.6%	\$346.34	\$379.20	9.5%	100.0%	100.0%	\$4,422	\$4,748	7.4%	9.5
Total Excluding \$50,000 +	935.4	948.9	1.4%	99.1%	98.6%	\$263.26	\$263.57	0.1%	76.0%	69.5%	\$3,377	\$3,333	-1.3%	0.1

Financial Summary

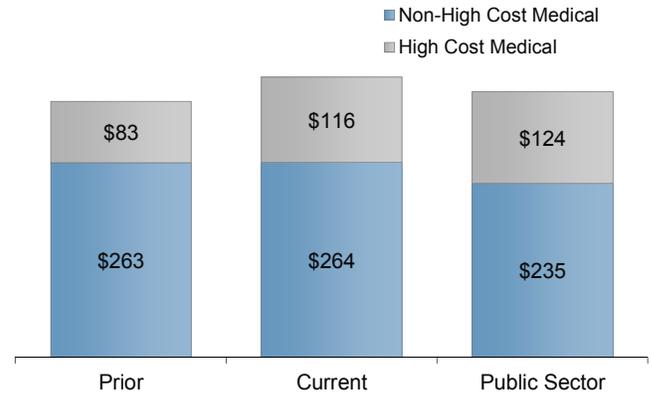
High Cost Claimants >= \$50,000

Excluding high cost claimants, medical net payments PMPM are trending at 0.1%.

High cost claims are an expected cost in any benefit plan, but exceptional amounts paid on a few claims may distort indicators of overall plan performance. In this report, a high cost claimant is defined as a member who has accumulated \$50,000 or more in medical net payments during the period under review. For calculations of non-high costs, the entire medical claim cost for each high cost claimant is removed.

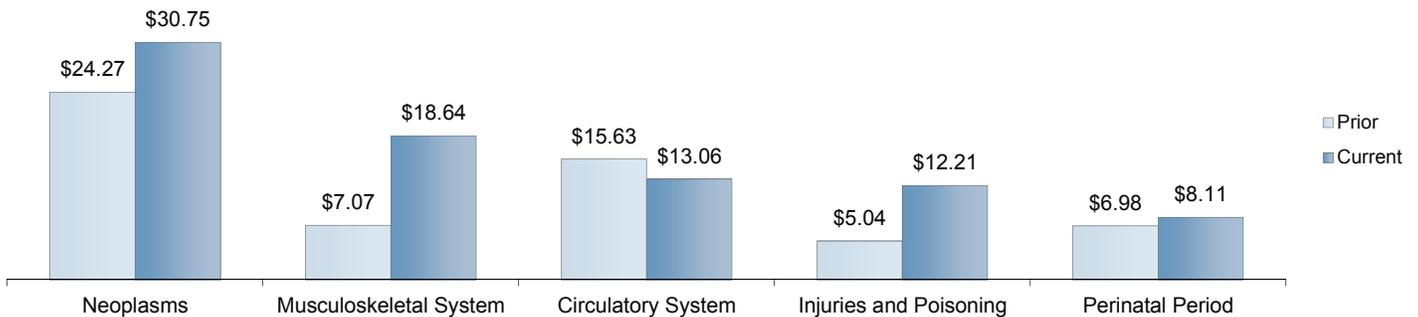
The frequency of high cost claims has increased 57.4% and the severity of the average high cost claim has decreased 11.6%. The combined impact of these variations has adversely affected overall trend.

Net Paid PMPM Cost Comparison



Measure	Non-High Cost Claimants			High Cost Claimants			All Claimants		
	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
Claimants	2,941	2,988	1.6%	26	41	57.7%	2,967	3,029	2.1%
Claimants per 1,000 Members	935.4	948.9	1.4%	8.27	13.02	57.4%	943.7	961.9	1.9%
Percent of Members	99.2%	98.7%	-0.5	0.8%	1.3%	0.5	100.0%	100.0%	0.0
Average Net Paid per Claimant	\$3,377	\$3,333	-1.3%	\$120,546	\$106,572	-11.6%	\$4,404	\$4,731	7.4%
Medical Net Paid PMPM	\$263.26	\$263.57	0.1%	\$83.07	\$115.63	39.2%	\$346.34	\$379.20	9.5%
Percent of Medical Net Paid PMPM	76.0%	69.5%	-6.5	24.0%	30.5%	6.5	100.0%	100.0%	0.0

Top Diagnosis Groups for High Cost Claimants (Net Paid PMPM)



Diagnosis Group	High Cost Claimants			High Cost Net Paid PMPM			High Costs as a % of Group Total		
	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
Neoplasms	14	17	21.4%	\$24.27	\$30.75	26.7%	79.8%	72.4%	-7.4
Musculoskeletal System	15	33	120.0%	\$7.07	\$18.64	163.5%	10.9%	23.9%	13.1
Circulatory System	15	26	73.3%	\$15.63	\$13.06	-16.4%	51.3%	53.9%	2.6
Injuries and Poisoning	11	25	127.3%	\$5.04	\$12.21	142.5%	18.8%	35.4%	16.6
Perinatal Period	2	2	0.0%	\$6.98	\$8.11	16.2%	69.5%	77.6%	8.1

Medical Plan Enrollment

Characteristics of the Covered Population

The age / gender risk for CITY OF SANTA FE members is 16.5% lower than the Public Sector (0.959 compared to 1.149).

Variations in the characteristics of a covered population can affect the indicators of overall benefit plan performance. While adjusting statistical measures for these differences is not always possible we can often provide data that will help to put plan, period and normative comparisons in perspective.

Population Measure	Prior	Current	Change	Public Sector	Variance
Enrolled Employees	1,240	1,237	-0.2%	-	-
Average Age	43.5	43.5	0.0%	-	-
% Female	28.7%	28.0%	-0.7	50.2%	-22.2
Enrolled Members	3,144	3,149	0.2%	-	-
Average Age	31.5	31.4	-0.3%	-	-
% Female	47.2%	47.2%	0.0	52.2%	-5.0
% Female (20 - 44)	19.0%	19.4%	0.4	-	-
% Children (<18)	30.3%	30.0%	-0.3	-	-
Average Family Size	2.54	2.55	0.4%	2.20	15.8%
Age / Gender Factor	0.960	0.959	-0.1%	1.149	-16.5%
Geographic Factor	1.039	1.039	0.0%	-	-
Combined Demographic Factor	0.997	0.996	-0.1%	-	-
Members Utilizing Medical Benefits	94.4%	96.2%	1.8	-	-

Putting Comparisons in Perspective

When analyzing CITY OF SANTA FE results against normative data, it is important to remember that the unique characteristics of each population may have a significant impact on the comparison. UnitedHealthcare has developed medical cost factors by age and gender that can help to determine if a difference in these member characteristics is impacting relative PMPM cost. The graph below illustrates how comparisons change when norms are adjusted for differences in the age/gender factor between CITY OF SANTA FE membership and that of each identified normative population. For each norm, the first column represents the actual PMPM cost and the second reflects the age/gender adjustment.

Age/Gender Adjusted Medical Net Paid PMPM Cost Comparison



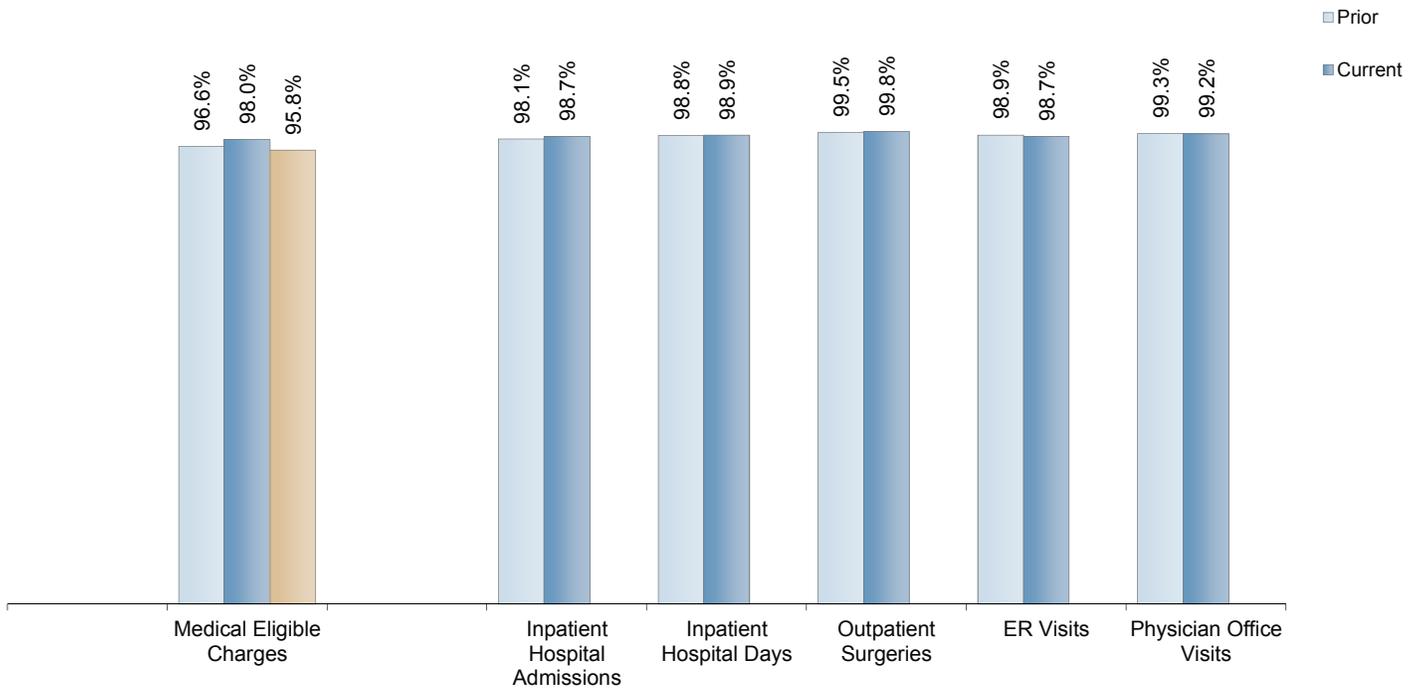
Cost Management

Network Value

Members used a network provider for 98.0% of eligible expenses, compared to 95.8% for the Public Sector.

Our strong network infrastructure features provider negotiations focused on achieving the best total outcome by combining our highly competitive discounts with transparent provider information for better decisions. We're committed to bringing optimal value to you and improved health outcomes for employees. The graphs below illustrate the distribution of selected measures according to whether or not a participating network provider was used.

Network Utilization Measures



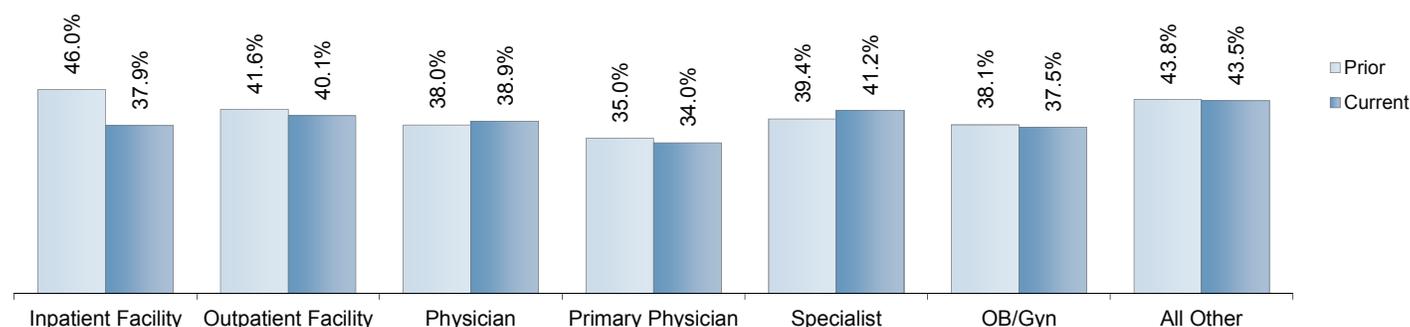
Cost Management

Network Discounts (medical)

The network discount rate for the current period was at 40.0%.

Our network of providers offers financial predictability through our long-term contracts with physicians and hospitals, competitive discounts, and consistent contract and rate structures. Although actual savings vary due to changes in the complexity of services and network utilization our highly competitive discounts help to deliver optimal value considering these factors. The chart and table below illustrate this value, which resulted in current period savings of \$9,269,576.

Network Discounts by Type of Service



Type of Service	Network Eligible Charges PMPM			Network Discounts PMPM			Percent Discount		
	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change
Inpatient Facility	\$110.31	\$118.44	7.4%	\$50.76	\$44.88	-11.6%	46.0%	37.9%	-8.1
Outpatient Facility	\$222.80	\$251.32	12.8%	\$92.61	\$100.77	8.8%	41.6%	40.1%	-1.5
Primary Physician	\$40.20	\$40.42	0.5%	\$14.07	\$13.75	-2.2%	35.0%	34.0%	-1.0
Specialist	\$87.16	\$90.19	3.5%	\$34.33	\$37.20	8.4%	39.4%	41.2%	1.9
OB/GYN	\$14.12	\$12.37	-12.4%	\$5.37	\$4.65	-13.5%	38.1%	37.5%	-0.5
All Other	\$96.20	\$101.29	5.3%	\$42.11	\$44.06	4.6%	43.8%	43.5%	-0.3
Total	\$570.79	\$614.03	7.6%	\$239.26	\$245.30	2.5%	41.9%	40.0%	-2.0

The \$6.05 PMPM increase in savings is the combined result of three factors. Savings will change because of 1) a variation in charges as a result of a change in the complexity of services rendered, better medicine or basic medical inflation, 2) changes in network utilization or 3) changes in negotiated provider contracts. The latter two factors deliver new savings that would not be generated if UnitedHealth Group did not play an active role in managing and expanding its networks. The value of these changes are:

- \$ 14.36 PMPM for changes in overall medical expenses.
- \$ 3.77 PMPM for changes in the portion of services rendered by network providers (98.0% versus 96.6% network use).
- \$ (12.08) PMPM for changes in negotiated provider contracts (40.0% versus 41.9% discounts).

Analysis indicates that, without increased network utilization, benefit payments would have increased an additional \$3.64 (\$3.77*96.6% gross benefit adequacy). This would have put current trend at 10.5%, as opposed to the 9.5% trend that has actually occurred. This incremental improvement reduced current expenses by \$137,618.

Additional Discounts

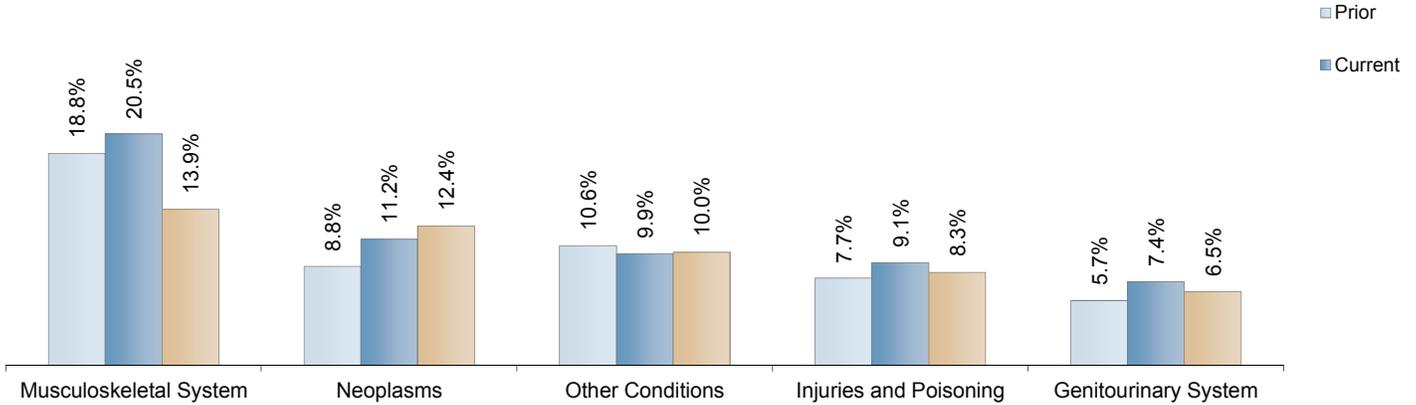
Additional savings may be generated through shared savings programs or from customer specific discount arrangements. The value of any discounts not stated above was \$10.34 PMPM, up 6.0% from the prior period. This additional value puts total discounts at \$255.64 PMPM, up 2.7%.

Distribution by Diagnosis

Claims related to 'Musculoskeletal System' diagnoses are a primary driver of medical costs.

Experience has been grouped into broad diagnostic categories to assist in the identification of illness patterns that are unique to your population and may have influenced your results. The following exhibit indicates some of the primary drivers of health care costs. The graph highlights the five groups representing the highest portion of medical payments.

Percent of Medical Net Payments



Cost and Utilization by Diagnosis Group *(in descending order by net paid amount)*

Diagnosis Group	Claimants per 1,000					Net Paid PMPM					HCC	ΔΔ
	Prior	Current	Change	Public Sect	Variance	Prior	Current	Change	Public Sect	Variance		
Musculoskeletal System	427.8	430.0	0.5%	315.4	36.3%	\$65.19	\$77.90	19.5%	\$49.80	56.4%	23.9%	3.7
Neoplasms	81.7	78.4	-4.0%	129.1	-39.2%	\$30.40	\$42.46	39.7%	\$44.45	-4.5%	72.4%	3.5
Other Conditions	580.8	595.7	2.6%	655.1	-9.1%	\$36.84	\$37.66	2.2%	\$36.03	4.5%	14.3%	0.2
Injuries and Poisoning	225.2	234.0	3.9%	186.7	25.4%	\$26.79	\$34.53	28.9%	\$29.67	16.4%	35.4%	2.2
Genitourinary System	250.0	246.1	-1.6%	308.7	-20.3%	\$19.91	\$28.15	41.3%	\$23.49	19.8%	26.8%	2.4
Circulatory System	140.3	131.8	-6.0%	222.7	-40.8%	\$30.46	\$24.24	-20.4%	\$35.19	-31.1%	53.9%	-1.8
Digestive System	143.4	140.0	-2.4%	145.4	-3.7%	\$25.85	\$23.92	-7.5%	\$26.58	-10.0%	14.8%	-0.6
Respiratory System	410.3	427.1	4.1%	378.3	12.9%	\$26.58	\$23.43	-11.8%	\$19.46	20.4%	9.5%	-0.9
Nervous System and Sense Organs	364.2	359.8	-1.2%	321.0	12.1%	\$24.04	\$21.26	-11.6%	\$22.63	-6.0%	6.7%	-0.8
Pregnancy and Childbirth	59.5	55.3	-7.1%	49.6	11.3%	\$15.40	\$16.05	4.2%	\$16.22	-1.0%	15.2%	0.2
Endocrine, Nutritional and Metabolic	210.6	195.3	-7.2%	265.6	-26.5%	\$10.56	\$13.40	26.9%	\$13.99	-4.2%	32.8%	0.8
Mental Diseases and Disorders	151.1	144.5	-4.4%	129.2	11.9%	\$12.78	\$12.05	-5.7%	\$10.67	12.9%	14.1%	-0.2
Perinatal Period	13.0	13.7	4.7%	17.1	-20.0%	\$10.04	\$10.45	4.1%	\$8.87	17.8%	77.6%	0.1
Skin and Subcutaneous Tissue	135.8	128.6	-5.3%	163.1	-21.2%	\$4.40	\$4.49	2.0%	\$5.39	-16.6%	16.8%	0.0
Infectious and Parasitic Diseases	306.9	330.9	7.8%	358.0	-7.6%	\$4.53	\$4.15	-8.3%	\$9.19	-54.8%	30.4%	-0.1
Congenital Anomalies	12.7	15.2	19.8%	17.2	-11.2%	\$0.67	\$3.24	386.8%	\$3.93	-17.5%	49.9%	0.7
Blood and Blood Forming Organs	25.4	25.4	-0.2%	33.8	-24.8%	\$1.89	\$1.83	-3.6%	\$3.80	-52.0%	31.6%	0.0
Total Medical	943.7	961.9	1.9%		0.0%	\$346.34	\$379.20	9.5%	\$359.36	5.5%	30.5%	9.5

ΔΔ Points Contributed to Medical Trend of 9.5%

Distribution by Diagnosis

Top Diagnosis Categories

Claims for 'Intervertebral Disc Disorders' and 'Other Connective Tissue Dis' accounted for 11.9% of current period medical payments.

Experience has been grouped into broad diagnostic categories to assist in the identification of illness patterns that are unique to your population and may have influenced your results. The following exhibit indicates some of the primary drivers of health care costs. The table displays the twenty five categories whose associated costs had the largest impact on total plan costs.

Cost and Utilization by Diagnosis Category *(in descending order by net paid amount)*

Diagnosis Category	Claimants per 1,000					Net Paid PMPM					% Total	ΔΔ
	Prior	Current	Change	Public Sect	Variance	Prior	Current	Change	Public Sect	Variance		
205 - Intervertebral Disc Disorders	271.0	280.1	3.4%	124.9	124.3%	\$33.60	\$31.43	-6.5%	\$18.61	68.9%	8.3%	-0.6
211 - Other Connective Tissue Dis	176.2	171.5	-2.7%	124.1	38.2%	\$11.31	\$13.63	20.5%	\$7.09	92.1%	3.6%	0.7
203 - Osteoarthritis	31.2	34.6	11.0%	37.3	-7.1%	\$4.00	\$12.27	206.6%	\$10.38	18.2%	3.2%	2.4
204 - Other Non-Traumatic Joint Dis	190.5	179.7	-5.7%	113.1	58.9%	\$11.43	\$11.16	-2.4%	\$5.04	121.3%	2.9%	-0.1
014 - Cancer of Colon	1.0	1.6	66.4%	1.5	3.8%	\$6.39	\$9.05	41.7%	\$1.48	509.7%	2.4%	0.8
047 - Other Benign Neoplasm	55.0	50.8	-7.7%	73.4	-30.8%	\$3.48	\$8.74	151.6%	\$5.09	72.0%	2.3%	1.5
218 - Liveborn	11.1	11.1	-0.2%	13.8	-19.3%	\$7.23	\$7.69	6.3%	\$5.87	30.8%	2.0%	0.1
134 - Other Upper Respiratory Dis	107.8	125.4	16.3%	78.8	59.2%	\$5.46	\$7.57	38.6%	\$3.09	144.8%	2.0%	0.6
225 - Trauma-Related Joint Dis	20.7	25.7	24.4%	21.3	20.5%	\$3.44	\$7.28	111.8%	\$3.45	111.0%	1.9%	1.1
256 - Medical Examination/Evalu	234.1	256.6	9.6%	261.0	-1.7%	\$5.83	\$7.23	23.9%	\$4.31	67.5%	1.9%	0.4
251 - Abdominal Pain	93.5	88.3	-5.6%	71.9	22.8%	\$8.18	\$7.13	-12.8%	\$5.34	33.5%	1.9%	-0.3
100 - Acute Myocardial Infarction	1.3	1.6	24.8%	1.5	3.8%	\$1.34	\$6.58	389.5%	\$2.54	158.8%	1.7%	1.5
126 - Other URI	252.9	268.3	6.1%	228.5	17.4%	\$7.37	\$6.21	-15.8%	\$4.16	49.3%	1.6%	-0.3
050 - Diabetes Mellitus With Complications	21.6	18.1	-16.3%	30.6	-40.8%	\$2.59	\$5.84	125.3%	\$2.63	121.7%	1.5%	0.9
232 - Sprains And Strains	94.5	93.4	-1.2%	68.6	36.2%	\$6.18	\$4.99	-19.2%	\$4.68	6.7%	1.3%	-0.3
102 - Nonspecific Chest Pain	45.5	46.0	1.2%	50.3	-8.4%	\$6.06	\$4.74	-21.6%	\$5.36	-11.4%	1.3%	-0.4
081 - Hereditary/Deg NS Condition	33.7	37.2	10.2%	34.5	7.6%	\$3.79	\$4.61	21.6%	\$2.98	54.7%	1.2%	0.2
258 - Screening Suspected Cond	164.4	147.7	-10.2%	216.6	-31.8%	\$5.28	\$4.60	-12.9%	\$7.64	-39.8%	1.2%	-0.2
158 - Chronic Renal Failure	1.3	3.2	149.6%	6.7	-52.4%	\$0.02	\$4.59	20059.3%	\$2.55	79.8%	1.2%	1.3
160 - Calculus Of Urinary Tract	9.9	11.4	15.9%	11.7	-2.0%	\$2.33	\$4.44	90.4%	\$2.96	50.3%	1.2%	0.6
259 - Residual Codes Unclassified	82.7	96.5	16.7%	91.2	5.9%	\$3.24	\$4.36	34.6%	\$4.21	3.7%	1.2%	0.3
230 - Fracture Of Lower Limb	11.5	11.1	-2.9%	10.3	7.7%	\$1.65	\$4.26	158.4%	\$2.17	96.7%	1.1%	0.8
254 - Rehab Care/Prostheses Fit	12.4	14.9	20.3%	16.9	-11.7%	\$4.38	\$4.25	-3.0%	\$3.31	28.2%	1.1%	0.0
244 - Inj/Cond Due To Ext Causes	76.0	72.4	-4.8%	43.8	65.5%	\$3.20	\$4.21	31.3%	\$1.98	112.6%	1.1%	0.3
210 - Lupus/Connective Tissue Dis	5.7	5.4	-5.7%	3.5	53.4%	\$0.34	\$4.21	1141.3%	\$0.51	729.9%	1.1%	1.1
Total For Top 25 Diagnosis Categories	-	-	-	-	-	\$148.14	\$191.08	29.0%	\$117.45	-	50.4%	12.4
All Other Diagnosis Categories	-	-	-	-	-	\$198.20	\$188.13	-5.1%	\$241.92	-	49.6%	-2.9
Total Medical	943.7	961.9	1.9%	-	-	\$346.34	\$379.20	9.5%	\$359.36	-	100.0%	9.5

ΔΔ Points Contributed to Medical Trend of 9.5%

Distribution by Diagnosis

Common Diagnoses

Intervertebral Disc Disorders accounted for \$31.43 PMPM (8.3% of total medical costs).

Experience has been grouped into broad diagnostic categories to assist in the identification of illness patterns that are unique to your population and may have influenced your results. The following exhibit displays cost and utilization for several common diagnosis categories.

Cost and Utilization by Common Diagnosis Category

Common Diagnosis Category	Claimants per 1,000					Net Paid PMPM						
	Prior	Current	Change	Public Sect	Variance	Prior	Current	Change	Public Sect	Variance	% Total	ΔΔ
Diabetes	-	-	-	-	-	\$4.68	\$7.77	66.0%	\$4.27	81.9%	2.0%	0.9
Diabetes without complications	48.0	57.5	19.7%	70.2	-18.1%	\$2.09	\$1.94	-7.5%	\$1.64	18.1%	0.5%	0.0
Diabetes with complications	21.6	18.1	-16.3%	30.6	-40.8%	\$2.59	\$5.84	125.3%	\$2.63	121.7%	1.5%	0.9
Hypertension	57.3	54.6	-4.6%	120.6	-54.7%	\$1.14	\$1.63	43.0%	\$2.05	-20.6%	0.4%	0.1
Coronary Artery Disease (CAD)	-	-	-	-	-	\$1.94	\$10.00	415.4%	\$7.43	34.7%	2.6%	2.3
Acute Myocardial Infarction	1.3	1.6	24.8%	1.5	3.8%	\$1.34	\$6.58	389.5%	\$2.54	158.8%	1.7%	1.5
Coronary Atherosclerosis	6.4	6.0	-5.2%	19.2	-68.6%	\$0.60	\$3.42	473.6%	\$4.88	-29.9%	0.9%	0.8
Congestive Heart Failure (CHF)	2.2	2.5	14.1%	3.5	-27.1%	\$12.14	\$1.22	-89.9%	\$1.93	-36.4%	0.3%	-3.2
Chronic Renal Failure	1.3	3.2	149.6%	6.7	-52.4%	\$0.02	\$4.59	#####	\$2.55	79.8%	1.2%	1.3
Chronic Obstructive Pulmonary Disease	18.4	24.8	34.3%	19.2	28.8%	\$0.31	\$0.49	57.5%	\$0.97	-49.9%	0.1%	0.1
Asthma	37.2	38.4	3.3%	35.7	7.5%	\$1.80	\$1.20	-33.6%	\$1.92	-37.7%	0.3%	-0.2
Intervertebral Disc Disorders	271.0	280.1	3.4%	124.9	124.3%	\$33.60	\$31.43	-6.5%	\$18.61	68.9%	8.3%	-0.6
Normal Pregnancy/Delivery	27.0	27.0	-0.2%	24.2	11.4%	\$2.84	\$2.37	-16.5%	\$2.63	-9.9%	0.6%	-0.1
Depression	42.9	48.3	12.4%	45.3	6.5%	\$2.22	\$2.91	30.9%	\$3.33	-12.6%	0.8%	0.2
Breast Cancer	3.5	3.2	-9.2%	8.8	-63.8%	\$3.21	\$2.61	-18.9%	\$6.24	-58.2%	0.7%	-0.2
Cervical Cancer	6.0	6.7	10.4%	6.0	10.6%	\$0.13	\$0.17	31.9%	\$0.34	-48.8%	0.0%	0.0
Colon Cancer	1.0	1.6	66.4%	1.5	3.8%	\$6.39	\$9.05	41.7%	\$1.48	509.7%	2.4%	0.8
Rheumatoid Arthritis	6.0	7.0	15.6%	7.1	-1.7%	\$0.41	\$0.66	59.7%	\$2.01	-67.4%	0.2%	0.1
Multiple Sclerosis	1.9	1.6	-16.8%	2.2	-27.2%	\$2.00	\$0.35	-82.6%	\$1.10	-68.3%	0.1%	-0.5
Enteritis/Ulcerative Colitis	3.2	2.5	-20.1%	4.8	-46.6%	\$0.52	\$0.61	16.9%	\$2.53	-75.9%	0.2%	0.0

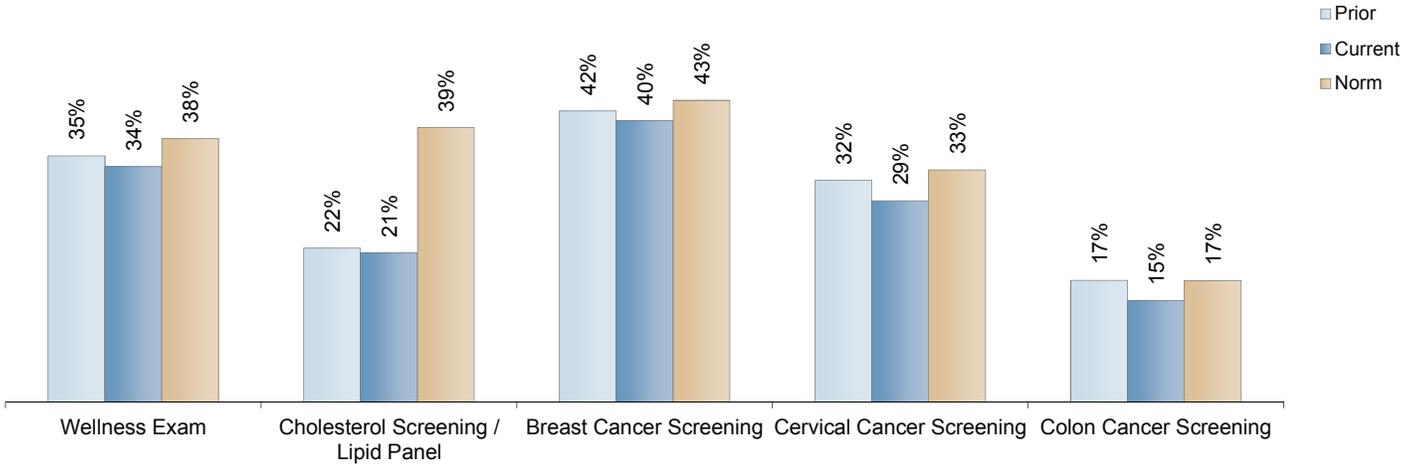
ΔΔ Points Contributed to Medical Trend of 9.5%

Utilization of Preventive Care Services

In the current period, 33.8% of covered individuals received a wellness physical exam.

This exhibit is intended to show utilization of services and is not a statement of member compliance with clinical guidelines. Because utilization is being measured, rather than compliance, targeted individuals may receive services in accordance with guidelines though report parameters may exclude their activity from these results. Target populations vary by type of service and are based on member age and/or gender.

Utilization of Preventive Care by Targeted Individuals



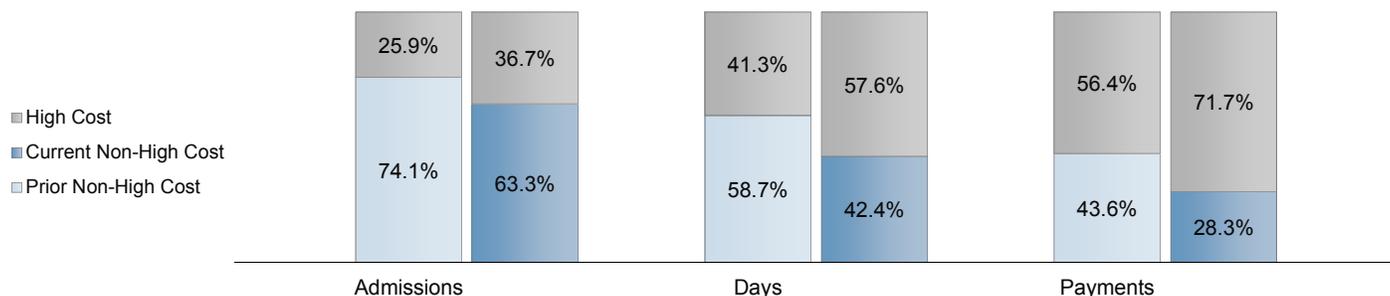
* The norm shown is for a 12 month period for selected United Healthcare book of business

Wellness Activity	Targeted Individuals			Targeted Individuals Receiving Care Within Each Period			Target Utilization Rate Within Each Period			Norm*	Variance
	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change		
Wellness Exam	3,408	3,514	3.1%	1,205	1,188	-1.4%	35.4%	33.8%	-1.6	37.8%	-4.0
Cholesterol Screening	1,257	1,268	0.9%	278	272	-2.2%	22.1%	21.5%	-0.7	39.4%	-18.0
Breast Cancer Screening	600	603	0.5%	251	244	-2.8%	41.8%	40.5%	-1.4	43.4%	-2.9
Cervical Cancer Screening	1,074	1,110	3.4%	342	321	-6.1%	31.8%	28.9%	-2.9	33.4%	-4.5
Colon Cancer Screening	663	680	2.6%	116	99	-14.7%	17.5%	14.6%	-2.9	17.5%	-2.9

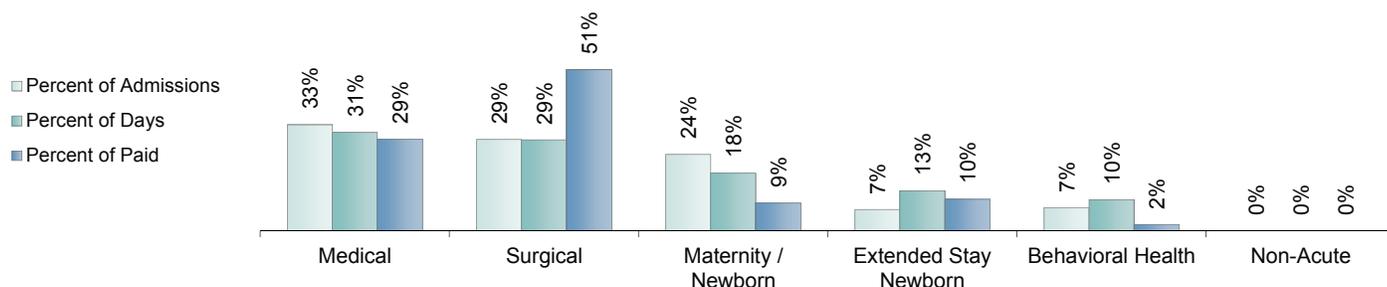
Inpatient Hospital Admissions

Net Paid PMPM costs for inpatient hospital admissions increased 35.5% to \$75.61 PMPM.

Inpatient hospital admissions contribute to a substantial portion of health care expenditure. As such, it is important to understand members' use of these services as well as its bearing on cost. The information on this page is intended to illustrate the utilization and cost associated with various components of admissions as well as the impact the high cost claimants have had on results.



Measure	Non-High Cost Claimants			High Cost Claimants			All Claimants			Public Secto	Variance
	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change		
Admissions per 1,000	37.2	30.2	-18.9%	13.0	17.5	33.9%	50.3	47.6	-5.2%	55.5	-14.2%
Days per 1,000	113.2	86.4	-23.7%	79.5	117.2	47.4%	192.7	203.6	5.6%	267.7	-23.9%
Average Length of Stay	3.04	2.86	-5.9%	6.10	6.71	10.0%	3.84	4.27	11.4%	4.82	-11.4%
Net Paid Per Admission	\$7,837	\$8,510	8.6%	\$28,964	\$37,247	28.6%	\$13,320	\$19,047	43.0%	\$19,003	0.2%
Net Paid Per Day	\$2,576	\$2,972	15.4%	\$4,750	\$5,552	16.9%	\$3,473	\$4,457	28.3%	\$3,942	13.1%
Net Paid PMPM	\$24.30	\$21.39	-12.0%	\$31.48	\$54.21	72.2%	\$55.78	\$75.61	35.5%	\$90.64	-16.6%



Admission Type	Days per 1,000			Average Net Paid per Day			Net Paid PMPM			Contribution to Trend	
	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	IP	Total
Medical	61.4	62.9	2.4%	\$3,274	\$4,155	26.9%	\$16.75	\$21.77	30.0%	9.0	1.4
Surgical	53.4	58.1	8.8%	\$6,589	\$7,904	20.0%	\$29.34	\$38.28	30.5%	16.0	2.6
Maternity / Newborn	37.5	36.8	-1.9%	\$1,883	\$2,136	13.4%	\$5.89	\$6.56	11.3%	1.2	0.2
Extended Stay Newborn	4.8	25.7	439.1%	\$4,920	\$3,489	-29.1%	\$1.96	\$7.48	282.3%	9.9	1.6
Behavioral Health	31.2	20.0	-35.8%	\$710	\$913	28.6%	\$1.84	\$1.52	-17.5%	-0.6	-0.1
Non-Acute	4.5	0.0	-100.0%	\$0	\$0	0.0%	\$0.00	\$0.00	0.0%	0.0	0.0
Total	192.7	203.6	5.6%	\$3,473	\$4,457	28.3%	\$55.78	\$75.61	35.5%	35.5	5.7
Delivery Type	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	IP	Total
Vaginal Delivery	24.2	21.3	-12.0%	\$1,580	\$1,773	12.2%	\$3.18	\$3.14	-1.2%	-0.1	0.0
C-Section	12.4	11.7	-5.3%	\$1,098	\$2,267	106.5%	\$1.13	\$2.22	95.6%	1.9	0.3
High Cost Claimant Impact	Prior	Current	Change	Prior	Current	Change	Prior	Current	Change	IP	Total
Non-High Cost Claimants	113.2	86.4	-23.7%	\$2,576	\$2,972	15.4%	\$24.30	\$21.39	-12.0%	-5.2	-0.8
High Cost Claimants	79.5	117.2	47.4%	\$4,750	\$5,552	16.9%	\$31.48	\$54.21	72.2%	40.8	6.6
High Cost Content	41.3%	57.6%	39.5%	-	-	-	56.4%	71.7%	27.1%	-	-

Outpatient Cost and Utilization

Members are using the Emergency Room at a rate of 188.6 visits per 1,000 members, 9.1% lower than the Public Sector.

Outpatient Surgeries and Emergency Room Visits

The data in this section includes aggregated facility costs for surgical procedures performed in an outpatient setting and for visits to an emergency room. Diagnostic procedures associated with each event will be included if the charges are submitted with the facility tax ID. The same applies to physician charges, although these are generally submitted separately under the physician tax ID and not included in aggregated costs.

Outpatient Surgeries	Prior	Current	Change	Public Sector	Variance
Surgeries per 1,000	132.0	128.0	-3.0%	159.0	-19.5%
Average Paid per Surgery	\$3,267	\$4,144	26.9%	\$3,296	25.7%
Net Paid PMPM	\$35.94	\$44.20	23.0%	\$45.03	-1.8%
Emergency Room Visits	Prior	Current	Change	Public Sector	Variance
Visits per 1,000	208.7	188.6	-9.6%	207.5	-9.1%
Average Paid per Visit	\$1,552	\$1,578	1.7%	\$1,154	36.8%
Net Paid PMPM	\$26.98	\$24.80	-8.1%	\$20.57	20.6%
Urgent Care Facility	Prior	Current	Change		
Visits per 1,000	84.9	62.2	-26.7%		
Average Paid per Visit	\$167.06	\$142.44	-14.7%		
Net Paid PMPM	\$1.18	\$0.74	-37.5%		

Outpatient Physician Office Visits

The data in this section includes outpatient office visits to a physician. Costs associated with the visit are identified based on CPT4 codes.

Primary Physician Office Visits	Prior	Current	Change	Public Sector	Variance
Visits per Member per Year	1.95	1.98	1.3%	2.07	-4.7%
Average Paid per Visit	\$109.53	\$111.01	1.4%	\$82.14	35.1%
Net Paid PMPM	\$17.82	\$18.30	2.7%	\$14.64	25.0%
OB / Gyn Office Visits	Prior	Current	Change	Public Sector	Variance
Visits per Member per Year	0.23	0.22	-2.1%	0.29	-23.1%
Average Paid per Visit	\$117.76	\$117.28	-0.4%	\$99.29	18.1%
Net Paid PMPM	\$2.23	\$2.17	-2.5%	\$2.46	-11.8%
Specialist Office Visits	Prior	Current	Change	Public Sector	Variance
Visits per Member per Year	1.25	1.17	-6.4%	1.64	-29.0%
Average Paid per Visit	\$161.93	\$167.62	3.5%	\$117.90	42.2%
Net Paid PMPM	\$16.85	\$16.32	-3.1%	\$16.66	-2.1%
Total Physician Office Visits	Prior	Current	Change	Public Sector	Variance
Visits per Member per Year	3.43	3.37	-1.7%	4.01	-16.0%
Average Paid per Visit	\$129.16	\$131.06	1.5%	\$97.79	34.0%
Net Paid PMPM	\$36.89	\$36.78	-0.3%	\$33.67	9.2%

Outpatient Diagnostic Services

The data in this section provides a summary of cost and utilization results for diagnostic services. Laboratory and radiology (MRI, CAT Scan, Ultrasound and Mammography) are included.

Laboratory	Prior	Current	Change		
Visits per 1,000	2,660	2,639	-0.8%		
Average Paid per Visit	\$86.26	\$82.37	-4.5%		
Net Paid PMPM	\$19.12	\$18.11	-5.3%		
Radiology	Prior	Current	Change		
Visits per 1,000	1,186	1,123	-5.3%		
Average Paid per Visit	\$294.88	\$313.15	6.2%		
Net Paid PMPM	\$29.15	\$29.30	0.5%		

Pharmacy

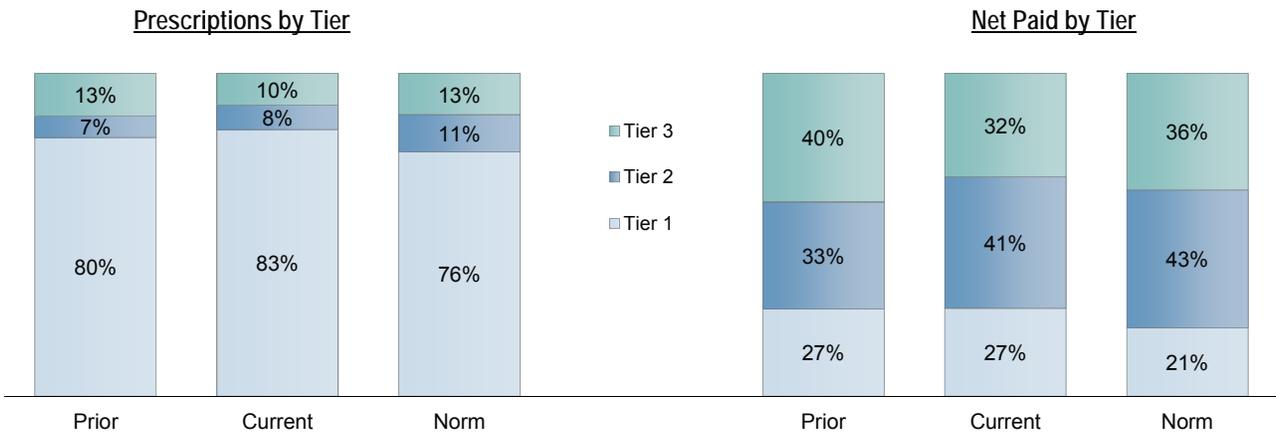
Pharmacy costs were \$56.36 PMPM, 12.9% of total payments.

Prescription drugs are an integral part of health care and should be considered in the context of total health care. The information on this page is intended to address the utilization and cost of prescription drugs among your employees and itemizes consumer preferences for the delivery of and cost savings options for prescription drugs.

Summary of Pharmacy Plan Performance

Measure	Prior	Current	Change	Public Sector	Variance
Enrolled Members	3,141	3,147	0.2%	-	-
Average Prescriptions PMPY	7.8	7.5	-3.8%	12.1	-38.1%
% Mail Order Utilization	10.3%	9.4%	-0.9	6.1%	3.3
Generic Substitution Rate	97.7%	97.6%	-0.1	-	-
Discounts PMPM (does not include rebates)	\$48.22	\$53.91	11.8%	-	-
Employee Cost Share PMPM	\$7.81	\$7.23	-7.4%	-	-
Net Benefit Adequacy	87.7%	88.6%	1.0	84.1%	4.5
Average Net Paid per Prescription	\$85.96	\$90.67	5.5%	\$83.20	9.0%
Net Paid PMPM	\$55.55	\$56.36	1.4%	\$83.60	-32.6%
Plan Payments	\$55.55	\$56.36	1.4%	-	-
HRA Payments	\$0.00	\$0.00	0.0%	-	-

Distribution by Prescription Tier



Prescription Tier	% of Prescriptions			% of Pharmacy Payments			Contribution to Trend
	Prior	Current	Change	Prior	Current	Change	Points
Tier 1	80.2%	82.7%	2.5	27.0%	27.3%	0.3	0.6
Tier 2	6.7%	7.6%	0.9	33.2%	40.7%	7.5	8.1
Tier 3	13.1%	9.7%	-3.4	39.8%	32.0%	-7.8	-7.3

Pharmacy

Top Drug Types

Prescriptions for 'Miscellaneous' represented the highest PMPM pharmacy cost at \$11.69.

Prescription drugs have been grouped into broad therapeutic categories to assist in the identification of cost and utilization patterns that are unique to your population and may have influenced your results. The following exhibit highlights the twenty five drug types representing the highest portion of pharmacy payments.

Top 25 Drugs by Therapeutic Class by Net Paid

Standard Therapeutic Class	Scripts per 1,000 per Year			Net Paid PMPM			% of Rx Net Paid		
	Prior	Current	Change	Prior	Current	Change	Prior	Current	ΔΔ
Miscellaneous	341.3	340.3	-0.3%	\$9.49	\$11.69	23.2%	17.1%	20.7%	4.0
Diabetic Therapy	373.4	334.3	-10.5%	\$6.56	\$6.70	2.2%	11.8%	11.9%	0.3
Anti-Ulcer Preps / Gastrointestinal Preps	311.0	279.0	-10.3%	\$3.44	\$2.79	-18.8%	6.2%	5.0%	-1.2
Antineoplastics	32.5	39.4	21.3%	\$0.90	\$2.69	199.8%	1.6%	4.8%	3.2
Antiarthritics	264.9	273.0	3.0%	\$2.60	\$2.64	1.4%	4.7%	4.7%	0.1
Bronchial Dilators	315.2	313.9	-0.4%	\$2.42	\$2.56	5.5%	4.4%	4.5%	0.2
Antivirals	109.2	110.6	1.3%	\$1.93	\$2.54	31.5%	3.5%	4.5%	1.1
Lipotropics	311.0	271.7	-12.7%	\$2.64	\$2.19	-17.0%	4.8%	3.9%	-0.8
Psychostimulants - Antidepressants	469.6	434.4	-7.5%	\$2.84	\$2.03	-28.5%	5.1%	3.6%	-1.5
All Other Dermatologicals	75.5	80.7	7.0%	\$1.49	\$1.50	0.9%	2.7%	2.7%	0.0
Other Hypotensives	401.8	374.3	-6.8%	\$1.55	\$1.41	-8.8%	2.8%	2.5%	-0.2
Systemic Contraceptives	341.0	344.5	1.0%	\$1.23	\$1.33	8.4%	2.2%	2.4%	0.2
Glucocorticoids	221.3	221.8	0.2%	\$1.27	\$1.29	2.1%	2.3%	2.3%	0.0
Diagnostics	86.0	63.2	-26.4%	\$1.68	\$1.18	-29.9%	3.0%	2.1%	-0.9
Anticonvulsants	161.1	153.8	-4.5%	\$1.11	\$1.13	1.9%	2.0%	2.0%	0.0
Androgens	50.9	48.0	-5.8%	\$1.06	\$1.12	5.9%	1.9%	2.0%	0.1
Narcotic Analgesics	625.6	556.4	-11.1%	\$2.03	\$1.00	-50.8%	3.6%	1.8%	-1.9
Ataractics - Tranquilizers	195.2	186.5	-4.4%	\$0.81	\$0.92	14.0%	1.5%	1.6%	0.2
Topical Nasal And Otic Preparations	230.5	245.9	6.7%	\$0.86	\$0.88	2.4%	1.5%	1.6%	0.0
Estrogens	86.9	93.7	7.9%	\$0.67	\$0.84	24.5%	1.2%	1.5%	0.3
Non-Narcotic Analgesics	75.8	69.6	-8.2%	\$0.98	\$0.77	-21.9%	1.8%	1.4%	-0.4
No Standard Therapeutic Class Code	75.1	91.5	21.8%	\$0.34	\$0.71	105.7%	0.6%	1.3%	0.7
Sedative Non-Barbiturate	139.1	112.8	-18.9%	\$0.66	\$0.63	-4.9%	1.2%	1.1%	-0.1
Other Hormones	13.7	11.4	-16.4%	\$0.81	\$0.60	-25.6%	1.5%	1.1%	-0.4
Adrenergics	15.6	19.1	22.2%	\$0.31	\$0.56	78.7%	0.6%	1.0%	0.4
All Other Drugs	2,432.3	2,388.9	-1.8%	\$5.88	\$4.66	-20.7%	10.6%	8.3%	-2.2
Total	7,755.5	7,458.8	-3.8%	\$55.55	\$56.36	1.4%	100.0%	100.0%	1.4

ΔΔ Points Contributed to Pharmacy Trend of 1.4%

Appendix

Glossary

Acronyms

HRA (Health Reimbursement Account)

A plan feature wherein an account is administered by UnitedHealthcare, into which an employer can contribute, and from which members can pay for qualified medical expenses.

HSA (Health Savings Account)

A tax-advantaged account that can be used by the consumer to pay for qualified health expenses for their family while covered by a high-deductible medical plan. HSA dollars can also be used to pay for non-medical expenses on a taxable basis (subject to penalty) if the participant withdraws money before age 65. Unused money remains in the account and grows tax deferred. An HSA is portable, employee owned, and can be carried over from one employer to the next.

IBNR (Incurred But Not Reported)

A factor applied to estimate the cost of services within a time period for which payments have not been processed.

PEPM (Per Employee Per Month)

The average revenues, expense or utilization of services for one employee for one month.

PMPM (Per Member Per Month)

The average revenues, expense or utilization of services for one member for one month.

PMPY (Per Member Per Year)

The average revenues, expense or utilization of services for one member for one year.

Benchmarks

Consumer Directed Average

Comparable measurements based upon accumulated data for Consumer Directed plans (HRA) generated for selected UnitedHealthcare book of business. The Consumer Directed comparator is not weighted for the characteristics of your covered population.

Industry Comparator

Comparable measurements based upon accumulated data related to your industry peers, generated to correlate with your current enrollment.

Market Comparator

Comparable measurements based upon accumulated data related to a subset of the overall book of commercial business, generated to correlate with your current enrollment based on geographic location.

National Comparator

Comparable measurements based upon accumulated data related to a subset of the overall book of commercial business, generated to correlate with your current enrollment.

Variance

The amount of difference between your current period experience and the comparable experience of an applicable benchmark.

Diagnosis Groups

AHRQ

A categorization of diagnosis groups, based on primary ICD-9 diagnosis codes, based on the national Agency on Healthcare Research and Quality clinical classification system.

Chapter 1 - Infectious and Parasitic Diseases

Tuberculosis, Septicemia, Bacterial and Viral Infections, HIV, Hepatitis, Measles, Herpes

Chapter 2 - Neoplasms

Benign Neoplasms, Malignant Neoplasms (Cancers) and Carcinomas

Glossary

Chapter 3 - Endocrine, Nutritional and Metabolic Diseases and Disorders

Thyroid Disorders, Diabetes, Hypoglycemia, Gout, Obesity, Nutritional Deficiencies

Chapter 4 - Blood and Blood Forming Organs

Anemia, Hemophilia, Splenectomy

Chapter 5 - Mental Diseases and Disorders

Affective and Personality Disorders, Senility, Depression, Eating Disorders, Mental Retardation, Drug Dependence

Chapter 6 - Nervous System and Sense Organs

Migraine, Epilepsy, Parkinson's, Meningitis, Multiple Sclerosis, Cataract, Glaucoma, Retinal Disorders, Otitis Media

Chapter 7 - Circulatory System

Hypertension, Chest Pain, Heart Disease, Cerebrovascular Disease, Diseases of the Blood Vessels and Lymphatics

Chapter 8 - Respiratory System

Pneumonia, Influenza, Tonsillitis, Bronchitis, Asthma, Respiratory Infections, Pulmonary Disease

Chapter 9 - Digestive System

Disorders of the Teeth and Jaw, Esophageal Disorders, Gastritis, Enteritis, Colitis, Appendicitis, Liver Disease

Chapter 10 - Genitourinary System

Genital Organ and Urinary System Disorders, Kidney Disease, Menstrual Disorders, Infertility

Chapter 11 - Pregnancy and Childbirth

Pregnancy, Delivery, Complications of Pregnancy and Childbirth, Contraception

Chapter 12 - Skin and Subcutaneous Tissue

Non-malignant Breast Conditions, Inflammatory Conditions, Infections of the Skin and Subcutaneous Tissue

Chapter 13 - Musculoskeletal System

Back Disorders, Arthropathies, Dorsopathies, Rheumatism, Osteopathies, and Acquired Deformities

Chapter 14 - Congenital Anomalies

Non-hereditary Conditions Existing at Birth

Chapter 15 - Perinatal Period

Liveborn, Short Gestation, Birth Trauma, Respiratory Distress, Perinatal Jaundice

Chapter 16 - Injuries and Poisoning

Fractures, Dislocation, Sprains and Strains, Open Wounds, Contusions, Poisoning, Burns

Chapter 17 - Other Conditions

Shock, Nausea and Vomiting, Abdominal Pain, Fatigue, Allergic Reactions, Medical Examination, Screening

Measures and Other Terminology

Adjusted Trend

Indicates what trend would have been if the selected measure was the same for the current period as it was for the prior period. It is important to note that each measure must be viewed in isolation. Because the change in any one measure may have an impact on another measure, the isolated impacts of each cannot be added together to determine a cumulative impact.

Age / Gender Factor

A factor indicating the expected relative cost of a population based solely on its age and gender composition.

Claimant

Glossary

A unique member for whom a claim was submitted for payment. Claimant counts exclude records where both the covered amount and the net paid amount equal zero.

Claim Rebundling

A system edit to group multiple services completed as part of the same procedure.

Combined Demographic Factor

A factor indicating the expected relative cost of a member based on the combination of the age / gender factor and the geographic factor.

Coordination of Benefits

A process that determines the order in which UnitedHealthcare will pay, as primary or secondary payer, when a member is enrolled in or covered under more than one insurance policy, or when primary coverage is under Medicare.

Cost Sharing Reductions

Those costs, if any, under a benefit plan that are the responsibility of the member, including deductibles, coinsurance, and copayments.

Covered Expenses

The total amount covered for reimbursement under the provisions of the benefit plan, after the application of discounts but prior to any member responsibility or coordination of benefits.

Duplicate Claim Screenings

The portion of the submitted charge that has been identified as previously billed by the provider.

Eligible Expenses

The total amount of health care expenses not excluded under the provisions of the benefit plan, shown before the application of any discounts and prior to any member responsibility or coordination of benefits.

Employee

The primary subscriber of health benefits. Employee counts are taken as an average per month across each time period.

Geographic Factor

A factor indicating the expected relative cost of a member based on their geographic location on record.

Gross Benefit Adequacy

The ratio of gross payments to covered expenses. Similar to net benefit adequacy, this measure excludes the impact of any coordination of benefits and is an indication of plan richness.

High Cost Claimant

A claimant whose total net payments for a given time period are equal to or in excess of \$50,000.

Ineligible Charge Reductions

Amount that is not covered for reasons other than duplicates.

Isolated Impact

The impact of a single plan performance measure on trend, assuming that all other measures remain constant.

Member

A person eligible for plan benefits. A member may be an employee, or the covered spouse or dependent of the employee. Member counts are taken as an average per month across each time period.

Net Benefit Adequacy

The ratio of net payments to covered expenses; an indication of plan richness.

Net Paid

The total amount paid by the plan, after the application of discounts and after any member responsibility and coordination of benefits.

Network Discount Percent

The ratio of discounts on claims paid under a provider contract to the eligible expenses for those same claims.

Glossary

Network Utilization

The ratio of eligible charges incurred in network to total eligible charges.

Non-High Cost Claims

The total claim cost excluding the experience of those members identified as high cost claimants.

Trend

Percentage increase or decrease in health care costs as compared to prior period costs.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com or by calling 1-866-844-4864.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network: \$0 Individual / \$0 Family Non-Network: \$300 Individual / \$600 Family Per Policy year. Copays, prescription drugs, and services listed below as "No Charge" do not apply to the deductible .	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: Unlimited Individual / Unlimited Family Non-Network: \$5,000 Individual / \$10,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premium , balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers ?	Yes. For a list of network providers , see myuhc.com or call 1-866-844-4864.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

Questions: Call 1-866-844-4864 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.



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

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copay per visit	50% co-ins after ded.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$10 copay per visit	50% co-ins after ded.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$10 copay per visit	50% co-ins after ded.	Benefits include diagnosis and related services and are limited to one visit and treatment per day. Cost share applies to manipulative (Spinal) services only and is limited to 24 visits per Policy year.
	Preventive care / screening / immunization	No Charge	50% co-ins after ded.	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% co-ins after ded.	None
	Imaging (CT / PET scans, MRIs)	No Charge	50% co-ins after ded.	None
If you need drugs to treat your illness or	Tier 1 – Your Lowest-Cost Option	Retail: \$10 copay Mail-Order: \$10 copay	Retail: \$10 copay	Provider means pharmacy for purposes of this section.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
condition More information about prescription drug coverage is available at myuhc.com	Tier 2 – Your Midrange-Cost Option	Retail: \$15 copay Mail-Order: \$15 copay	Retail: \$15 copay	Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-notification requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 3 – Your Highest-Cost Option	Not Covered	Not Covered	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$75 copay per visit	50% co-ins after ded.	None
	Physician / surgeon fees	No Charge	50% co-ins after ded.	None
If you need immediate medical attention	Emergency room services	\$125 copay per visit	Same as Network	None
	Emergency medical transportation	No Charge	Same as Network	None
	Urgent care	\$10 copay per visit	50% co-ins after ded.	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay per inpatient stay	50% co-ins after ded.	pre-notification is required non-network or a \$250 penalty will apply.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician / surgeon fees	No Charge	50% co-ins after ded.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	\$10 copay per visit	20% after deductible if prior authorization is received 50% after deductible if no authorization is received	pre-notification is required non-network for certain services or benefit reduces to 50% of eligible expenses.
	Mental / Behavioral health inpatient services	No Charge	20% after deductible if prior authorization is received 50% after deductible if no authorization is received.	pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Substance use disorder outpatient services	\$10 copay per visit	20% after deductible if prior authorization is received 50% after deductible if no authorization is received.	pre-notification is required non-network for certain services or benefit reduces to 50% of eligible expenses.
If you are pregnant	Substance use disorder inpatient services	No Charge	20% after deductible if prior authorization is received 50% after deductible if no authorization is received.	pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Prenatal and postnatal care	\$10 copay, initial visit	50% co-ins after ded.	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	\$250 copay per inpatient stay	50% co-ins after ded.	Inpatient pre-notification may apply. Your cost for inpatient services only. Delivery Services cost share is reflected in "Physician/surgeon fees" above.
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Limited to 100 visits per Policy year. pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Rehabilitation services	No Charge	50% co-ins after ded.	Limited to 60 visits per therapy, per Policy year.
	Habilitative services	No Charge	50% co-ins after ded.	Limits are combined with Rehabilitation Services limits listed above.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Skilled nursing care	No Charge	No Charge	Limited to 90 days per Policy year (combined with inpatient rehabilitation). pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Durable medical equipment	No Charge	50% co-ins after ded.	pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Hospice service	No Charge	50% co-ins after ded.	Limited to 180 days per Policy year. Inpatient pre-notification is required for non-network or benefit reduces to 50% of eligible expenses.
If your child needs dental or eye care	Eye exam	\$10 copay per outpatient visit	50% co-ins after ded.	Refractive eye examinations are covered in network only and are limited to one exam every other Policy year.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

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

<ul style="list-style-type: none"> Bariatric surgery Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult/Child) Glasses (Adult/Child) Hearing aids Infertility treatment 	<ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing 	<ul style="list-style-type: none"> Routine foot care Weight loss Programs
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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

<ul style="list-style-type: none"> Acupuncture– limitations may apply 	<ul style="list-style-type: none"> Chiropractic care – limitations may apply 	<ul style="list-style-type: none"> Routine eye care (Adult/Child) – limitations may apply
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Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-844-4864.

Chinese (中文): **如果需要中文的帮助**, 请拨打这个号码1-866-844-4864.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-866-844-4864.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-844-4864.

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

About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,340
- Patient pays \$200

Sample care costs:

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

Patient pays:

Deductibles	\$0
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$200

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

- Amount owed to providers: \$5,400
- Plan pays \$5,320
- Patient pays \$80

Sample care costs:

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

Patient pays:

Deductibles	\$0
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$80

Questions and answers about Coverage Examples:

<p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include <u>premiums</u>. • Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan. • The patient's condition was not an excluded or preexisting condition. • All services and treatments started and ended in the same coverage period. • There are no other medical expenses for any member covered under this plan. • Out-of-pocket expenses are based only on treating the condition in the example. • The patient received all care from in-network <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher. • If other than individual coverage, the Patient Pays amount may be more. 	<p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p>	<p>Can I use Coverage Examples to compare plans?</p> <p>✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.</p>
<p>Does the Coverage Example predict my own care needs?</p> <p>✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.</p>	<p>Does the Coverage Example predict my future expenses?</p> <p>✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <u>providers</u> charge, and the reimbursement your health plan allows.</p>	<p>Are there other costs I should consider when comparing plans?</p> <p>✓ Yes. An important cost is the <u>premium</u> you pay. Generally, the lower your <u>premium</u>, the more you'll pay in out-of-pocket costs, such as <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p>

Questions: Call 1-866-844-4864 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy. **This is only a summary.** It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com or by calling 1-866-844-4864.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	Network: \$100 Individual / \$200 Family Non-Network: \$300 Individual / \$600 Family Per Policy year. Copays, prescription drugs, and services listed below as "No Charge" do not apply to the <u>deductible</u> .	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Network: \$1,000 Individual / \$2,000 Family Non-Network: \$5,000 Individual / \$10,000 Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> , balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of <u>network providers</u> , see myuhc.com or call 1-866-844-4864.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-866-844-4864 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.



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

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay per visit	50% co-ins after ded.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$15 copay per visit	50% co-ins after ded.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$15 copay per visit	50% co-ins after ded.	Benefits include diagnosis and related services and are limited to one visit and treatment per day. Cost share applies to manipulative (Spinal) services only and is limited to 24 visits per Policy year.
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. No coverage non-network.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-ins after ded.	50% co-ins after ded.	None
	Imaging (CT / PET scans, MRIs)	10% co-ins after ded.	50% co-ins after ded.	None
If you need drugs to treat your	Tier 1 – Your Lowest-Cost Option	Retail: \$10 copay Mail-Order: \$20 copay	Retail: \$10 copay	Provider means pharmacy for purposes of this section.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
illness or condition More information about prescription drug coverage is available at myuhc.com	Tier 2 – Your Midrange-Cost Option	Retail: \$20 copay Mail-Order: \$40 copay	Retail: \$20 copay	Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-notification requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 3 – Your Highest-Cost Option	Retail: \$40 copay Mail Order: \$80 copay	Retail: \$40 copay	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-ins after ded.	50% co-ins after ded.	None
	Physician / surgeon fees	10% co-ins after ded.	50% co-ins after ded.	None
If you need immediate medical attention	Emergency room services	\$175 copay per visit	Same as Network	None
	Emergency medical transportation	10% co-ins after ded.	Same as Network	None
	Urgent care	\$35 copay per visit	50% co-ins after ded.	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-ins after ded.	50% co-ins after ded.	pre-notification is required non-network or benefit reduces to 50% of eligible expenses.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician / surgeon fees	10% co-ins after ded.	50% co-ins after ded.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	10% co-ins after ded.	20% after deductible if prior authorization is received 50% after deductible if no authorization is received.	pre-notification is required non-network for certain services or benefit reduces to 50% of eligible expenses.
	Mental / Behavioral health inpatient services	10% co-ins after ded.	20% after deductible if prior authorization is received 50% after deductible if no authorization is received.	pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Substance use disorder outpatient services	\$15 copay per visit	20% after deductible if prior authorization is received 50% after deductible if no authorization is received.	pre-notification is required non-network for certain services or benefit reduces to 50% of eligible expenses.
	Substance use disorder inpatient services	10% co-ins after ded.	20% after deductible if prior authorization is received 50% after deductible if no authorization is received.	pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
If you are pregnant	Prenatal and postnatal care	\$15 copay, initial visit	50% co-ins after ded.	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	10% co-ins after ded.	50% co-ins after ded.	Inpatient pre-notification may apply.
If you need help recovering or have other special health needs	Home health care	10% co-ins after ded.	50% co-ins after ded.	Limited to 100 visits per Policy year. pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Rehabilitation services	\$15 copay per outpatient visit	50% co-ins after ded.	Limited to 30 visits per therapy, per Policy year.
	Habilitative services	\$15 copay per outpatient visit	50% co-ins after ded.	Limits are combined with Rehabilitation Services limits listed above.
	Skilled nursing care	10% co-ins after ded.	50% co-ins after ded.	Limited to 60 days per Policy year (combined with inpatient rehabilitation). pre-notification is required non-network or

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
				benefit reduces to 50% of eligible expenses.
	Durable medical equipment	10% co-ins after ded.	50% co-ins after ded.	pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Hospice service	10% co-ins after ded.	50% co-ins after ded.	Limited to 180 days per Policy year. Inpatient pre-notification is required for non-network or benefit reduces to 50% of eligible expenses.
If your child needs dental or eye care	Eye exam	\$15 copay per outpatient visit	50% co-ins after ded.	Refractive eye examinations are covered in network only and are limited to one exam every other policy year.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)			
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult/Child) Glasses (Adult/Child) Hearing aids Infertility treatment 	<ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing 	<ul style="list-style-type: none"> Routine foot care Weight loss Programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)			
<ul style="list-style-type: none"> Chiropractic care – limitations may apply 	<ul style="list-style-type: none"> Routine eye care (Adult/Child) – limitations may apply 		

Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-844-4864.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-844-4864.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-844-4864.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-844-4864.

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

About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,520
- Patient pays \$1,020

Sample care costs:

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

Patient pays:

Deductibles	\$100
Copays	\$20
Coinsurance	\$700
Limits or exclusions	\$200
Total	\$1,020

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

- Amount owed to providers: \$5,400
- Plan pays \$4,420
- Patient pays \$980

Sample care costs:

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

Patient pays:

Deductibles	\$100
Copays	\$800
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$980

Questions and answers about Coverage Examples:

<p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include <u>premiums</u>. • Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan. • The patient's condition was not an excluded or preexisting condition. • All services and treatments started and ended in the same coverage period. • There are no other medical expenses for any member covered under this plan. • Out-of-pocket expenses are based only on treating the condition in the example. • The patient received all care from in-network <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher. • If other than individual coverage, the Patient Pays amount may be more. 	<p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p>	<p>Can I use Coverage Examples to compare plans?</p> <p>✓ <u>Yes</u>. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.</p>
	<p>Does the Coverage Example predict my own care needs?</p> <p>✗ <u>No</u>. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.</p>	<p>Are there other costs I should consider when comparing plans?</p> <p>✓ <u>Yes</u>. An important cost is the <u>premium</u> you pay. Generally, the lower your <u>premium</u>, the more you'll pay in out-of-pocket costs, such as <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p>
	<p>Does the Coverage Example predict my future expenses?</p> <p>✗ <u>No</u>. Coverage Examples are <u>not</u> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <u>providers</u> charge, and the reimbursement your health plan allows.</p>	

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



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at welcometouhc.com or by calling 1-866-734-7670.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Network: \$1,500 Individual / \$3,000 Family Non-Network: \$3,000 Individual / \$6,000 Family Per Policy year. Prescription drugs, and services listed below as "No Charge" do not apply to the <u>deductible</u> . HRA Employer Contribution: \$500 Individual / \$1,000 Individual + 1 or Family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Network: \$3,000 Individual / \$6,000 Family Non-Network: \$6,000 Individual / \$12,000 Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premium</u> , balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of <u>network providers</u> , see myuhc.com or call 1-866-734-7670.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-866-734-7670 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

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



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

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-ins after ded.	50% co-ins after ded.	None
	Specialist visit	20% co-ins after ded.	50% co-ins after ded.	None
	Other practitioner office visit	20% co-ins after ded.	50% co-ins after ded.	Benefits include diagnosis and related services and are limited to one visit and treatment per day. Cost share applies to manipulative (Spinal) services only and is limited to 24 visits per Policy year.
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. No coverage non-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins after ded.	50% co-ins after ded.	None
	Imaging (CT / PET scans, MRIs)	20% co-ins after ded.	50% co-ins after ded.	None
If you need drugs to treat your illness or	Tier 1 – Your Lowest-Cost Option	Retail: \$15 copay Mail-Order: \$30 copay	Retail: \$15 copay	Provider means pharmacy for purposes of this section.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
condition More information about prescription drug coverage is available at myuhc.com	Tier 2 – Your Midrange-Cost Option	Retail: \$30 copay Mail-Order: \$60 copay	Retail: \$30 copay	Retail: Up to a 31 day supply Mail-Order: Up to a 90 day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-notification requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 3 – Your Highest-Cost Option	Retail: \$60 copay Mail Order: \$120 copay	Retail: \$60 copay	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins after ded.	50% co-ins after ded.	None
	Physician / surgeon fees	20% co-ins after ded.	50% co-ins after ded.	None
If you need immediate medical attention	Emergency room services	\$225 copay per visit	Same as Network	None
	Emergency medical transportation	20% co-ins after ded.	Same as Network	None
	Urgent care	\$50 copay per visit	50% co-ins after ded.	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply. pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins after ded.	50% co-ins after ded.	pre-notification is required non-network or benefit reduces to 50% of eligible expenses.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Physician / surgeon fees	20% co-ins after ded.	50% co-ins after ded.	None
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	20% co-ins after ded.	20% after deductible if prior authorization is received 50% after deductible if no authorization is received	pre-notification is required non-network for certain services or benefit reduces to 50% of eligible expenses.
	Mental / Behavioral health inpatient services	20% co-ins after ded.	20% after deductible if prior authorization is received 50% after deductible if no authorization is received	pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Substance use disorder outpatient services	20% co-ins after ded.	20% after deductible if prior authorization is received 50% after deductible if no authorization is received	pre-notification is required non-network for certain services or benefit reduces to 50% of eligible expenses.
	Substance use disorder inpatient services	20% co-ins after ded.	20% after deductible if prior authorization is received 50% after deductible if no authorization is received	pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
If you are pregnant	Prenatal and postnatal care	20% co-ins after ded.	50% co-ins after ded.	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	20% co-ins after ded.	50% co-ins after ded.	Inpatient pre-notification may apply.
If you need help recovering or have other special health needs	Home health care	20% co-ins after ded.	50% co-ins after ded.	Limited to 100 visits per Policy year. pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Rehabilitation services	20% co-ins after ded.	50% co-ins after ded.	Limits per Policy year: physical, speech, occupational – 20 visits; cardiac – 36 visits;

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

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
				pulmonary – 20 visits.
	Habilitative services	20% co-ins after ded.	50% co-ins after ded.	Limits are combined with Rehabilitation Services limits listed above.
	Skilled nursing care	20% co-ins after ded.	50% co-ins after ded.	Limited to 30 days per Policy year (combined with inpatient rehabilitation). pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Durable medical equipment	20% co-ins after ded.	50% co-ins after ded.	pre-notification is required non-network or benefit reduces to 50% of eligible expenses.
	Hospice service	20% co-ins after ded.	50% co-ins after ded.	Limited to 180 days per Policy year. Inpatient pre-notification is required for non-network or benefit reduces to 50% of eligible expenses.
If your child needs dental or eye care	Eye exam	20% co-ins after ded.	50% co-ins after ded.	Refractive eye examinations are covered in network only and are limited to one exam every other Policy year.
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)			
<ul style="list-style-type: none"> Bariatric surgery Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult/Child) Glasses (Adult/Child) Hearing aids Infertility treatment 	<ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing 	<ul style="list-style-type: none"> Routine foot care Weight loss Programs
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)			
<ul style="list-style-type: none"> Acupuncture– limitations may apply 	<ul style="list-style-type: none"> Chiropractic care – limitations may apply 	<ul style="list-style-type: none"> Routine eye care (Adult/Child) – limitations may apply 	

Your Rights to Continue Coverage:

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

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

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Member Service number listed on the back of your ID card or visit www.myuhc.com.

Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-734-7670.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-734-7670.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwüjigo holne' 1-866-734-7670.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-734-7670.

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

About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,620
- Patient pays \$2,920

Sample care costs:

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

Total **\$7,540**

Patient pays:

Deductibles	\$1,500
Copays	\$20
Coinsurance	\$1,200
Limits or exclusions	\$200

Total **\$2,920**

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

- Amount owed to providers: \$5,400
- Plan pays \$2,920
- Patient pays \$2,480

Sample care costs:

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

Total **\$5,400**

Patient pays:

Deductibles	\$1,500
Copays	\$800
Coinsurance	\$100
Limits or exclusions	\$80

Total **\$2,480**

Questions and answers about Coverage Examples:

<p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include <u>premiums</u>. • Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan. • The patient's condition was not an excluded or preexisting condition. • All services and treatments started and ended in the same coverage period. • There are no other medical expenses for any member covered under this plan. • Out-of-pocket expenses are based only on treating the condition in the example. • The patient received all care from in-network <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher. • If other than individual coverage, the Patient Pays amount may be more. 	<p>What does a Coverage Example show?</p> <p>For each treatment situation, the Coverage Example helps you see how <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.</p>	<p>Can I use Coverage Examples to compare plans?</p> <p>✓ <u>Yes</u>. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.</p>
	<p>Does the Coverage Example predict my own care needs?</p> <p>✗ <u>No</u>. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.</p>	<p>Are there other costs I should consider when comparing plans?</p> <p>✓ <u>Yes</u>. An important cost is the <u>premium</u> you pay. Generally, the lower your <u>premium</u>, the more you'll pay in out-of-pocket costs, such as <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.</p>
	<p>Does the Coverage Example predict my future expenses?</p> <p>✗ <u>No</u>. Coverage Examples are <u>not</u> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <u>providers</u> charge, and the reimbursement your health plan allows.</p>	

Questions: Call 1-866-734-7670 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy. **This is only a summary.** It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

City of Santa Fe Wellness Program Update (12/30/2014)

The Wellness Program expansion which includes the Recreation Benefit was approved by City Council on August 8, 2012. The Recreation Benefit (free membership to GCCC for employees and family members who qualify) was effective January 1, 2013. This interim report provides documentation of program elements that have been implemented, and level of engagement by employees and family members at this time. A 12 month summary report will be provided in January 2014, the anniversary of program effective date.

The most useful measure of Wellness Program impact is the percent engagement (or participation) of the total population. In the case of the City of Santa Fe, a goal was set for employees only, but we are documenting and tabulating numbers for family members as well as they have a significant impact on our Health Care costs.

Goal Year Two (December 2014): 20%

Actual employee participation: 43.7% or 699 employees

Actual participation of employees plus family members: 33.8% or 1122 people.

These totals represent attendance at, or participation in any City Sponsored Wellness event during this time.

Recreation benefit issued (GCCC membership): 413 employees or 25.8%, based on 1600 employees.

Recreation benefit (GCCC membership) employees and family members: 768 people or 23%, based on UHC total covered population of 3315.

Additional program interventions based on highest cost drivers:

- **Back Care:** 10 Back Care workshops with a total of 64 attending.
- **Chronic Renal Failure (Diabetes and Hypertension are major causes of CRF):** Blood pressure screening and education at (7) Biometric screening events attended by a total of 84; Diabetes Prevention Program provided to employees and family members with or at risk for Pre-Diabetes 10 participants.
- **Increased Fitness: Mayor's Gold Cup Health & Fitness Challenge** completed with 31 teams and a total of 171 Participants or 10.7% of the workforce.
- **Financial Fitness:** 6 one hour programs with attendance total of: 53
- **Healthy Safe Holidays:** 2 classes, 14 attendees
- **Immune Health:** 1 class, 18 attendees

- **Healthy Cooking:** 2 classes, 10 attendees
- **Sprains & Strains:** 1 class, 8 attendees
- **Emergency Room Overuse:** The NurseLine Prize Patrol campaign aims to inform and orient employees to alternative and more cost effective care for non-emergent medical issues. Prizes are given to employees who are found by Wellness Program representatives to have the NurseLine phone number in their cell phone directory. Ongoing email blasts advertise the campaign.

Clearly the Wellness Program is on track to meet the 3rd year goals and in fact has exceeded the primary goal measure of participation. The amount of employee outreach, program design, coordination, execution, tracking and documentation, and follow up is enormous for our engaged population. The current staffing of one Wellness Coordinator (32 hours per week) and Assistant at 32 hours a week is not sufficient to support the overwhelming response to this program. Taking the assistant hours to 40 hours a week would allow us to continue to support and expand our outreach to City employees.

UnitedHealthcare Vision
UnitedHealthcare Insurance Company
Certificate of Coverage

For

City of Santa Fe

GROUP NUMBER: 712215

EFFECTIVE DATE: July 1, 2011

UnitedHealthcare Insurance Company

Group Vision Care Certificate of Coverage

Issued To: City of Santa Fe ("Enrolling Group")
Policy Number: 712215
Policy Effective Date: July 1, 2011
Policy Anniversary Date: July 1

This *Certificate of Coverage* ("*Certificate*") sets forth your rights and obligations as a Covered Person. It is important that you READ YOUR *CERTIFICATE* CAREFULLY and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Enrolling Group.

UnitedHealthcare Insurance Company (the "Company") agrees with the Enrolling Group to provide coverage for Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Enrolling Group's application and payment of the required Policy Charges. The Enrolling Group's application is made a part of the Policy.

Many words used in this *Certificate* and the attached *Table of Benefits* have special meanings. These words will appear capitalized and are defined for you in *Section 1: Definitions*. By reviewing these definitions, you will have a clearer understanding of your *Certificate* and *Table of Benefits*.

When we use the words "we", "us", "our", and "the Company" in this *Certificate*, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your", we are referring to the people who are Covered Persons as the term is defined in *Section 1: Definitions*.

The Policy is delivered in and governed by the laws of the State of New Mexico.

Group Vision Care Certificate of Coverage

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Section 1: Definitions

Copayment - The charge, in addition to the Premium, that you are required to pay to a Network Provider for certain Services payable under the Policy. You are responsible for the payment of any Copayment directly to the provider of the Service at the time of service, or when billed by the provider.

Covered Person - The Subscriber or an Enrolled Dependent but this term applies only while the person is enrolled under the Policy. Reference to "you" and "your" throughout this *Certificate* are references to Covered Persons.

Covered Contact Lens Selection - A selection of available contact lenses that may be obtained from a Network Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Covered Eyeglass Frames Selection - A selection of available eyeglass frames that may be obtained from a Network Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Dependent - A Covered Person who is:

1. The Subscriber's legal spouse. All references to the spouse of a Subscriber shall include Domestic Partner; or
2. A dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse). The term "child" also includes a grandchild of either the Subscriber or the Subscriber's spouse. To be eligible for coverage under the Policy, a Dependent must principally reside within the United States. The term "Dependent" will not include any unmarried dependent child 25 years of age or older, except as stated in *Section 3: Termination Provisions* section titled "*Extended Coverage for Handicapped Dependent Children*".

The Subscriber agrees to reimburse the Company for any Services provided to the child at a time when the child did not satisfy these conditions.

The term "Dependent" also includes a child for whom coverage for Services is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a 'Qualified Medical Child Support Order'.

The term "Dependent" does not include anyone who is also enrolled as a Subscriber, nor can anyone be a "Dependent" of more than one Subscriber.

Domestic Partner - A person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership. In no event will a person's legal spouse be considered a Domestic Partner.

Domestic Partnership - A relationship between the Subscriber and one other person of the opposite or same sex. The following requirements apply to both persons:

- They share the same permanent residence and the common necessities of life;
- They are not related by blood or a degree of closeness which would prohibit marriage in the law of state in which they reside;
- Each is at least 18 years of age;
- Each is mentally competent to consent to contract;
- Neither is currently married to another person under either a statutory or common law;
- They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:

- Have a single dedicated relationship of at least 6 months duration.
- Joint ownership of residence.
- At least two of the following:
 - ◆ Joint ownership of an automobile.
 - ◆ Joint checking, bank or investment account.
 - ◆ Joint credit account.
 - ◆ Lease for a residence identifying both partners as tenants.
 - ◆ A will and/or life insurance policies which designates the other as primary beneficiary.
- The Subscriber and Domestic Partner must jointly sign an affidavit of Domestic Partnership.

Eligible Person - A person who meets all applicable eligibility requirements for vision care coverage.

Enrolled Dependent - A Dependent who is properly enrolled for coverage under the Policy.

Enrolling Group - The employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental, Investigational or Unproven Services - Medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

- A. Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- B. Subject to review and approval by any institutional review board for the proposed use; or
- C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services - Services provided outside the U.S. and U.S. Territories.

Network Benefits - Coverage for Services provided by a Network Provider.

Non-Network Benefits - Coverage for Services provided by a provider other than a Network Provider.

Network Provider - Any optometrist, ophthalmologist, optician or other person who may lawfully provide Services who has contracted, directly or indirectly, with us, to provide Services to Covered Persons participating in our vision plans.

Plan Year - A period of time beginning with the Policy Anniversary Date of any year and terminating exactly one year later. If the Policy Anniversary Date is February 29, such date will be considered to be February 28 in any year having no such date.

Policy - The Group Vision Care Insurance Policy issued to the Enrolling Group.

Premium - The periodic fee required to maintain coverage of Covered Persons in accordance with the terms of the Policy.

Service - Any covered benefit listed in *Section 4: Benefits* of this *Certificate*.

Subscriber - An Eligible Person who is properly enrolled for coverage under the Policy and is the person on whose behalf the Policy is issued to the Enrolling Group.

Section 2: Eligibility and Effective Dates

Effective Date of Coverage

In no event is there coverage for Services rendered or delivered before the effective date of coverage. Coverage will be effective subject to any applicable waiting period required by the Enrolling Group.

Enrollment

Eligible Persons may enroll themselves and their Dependents for coverage under the Policy during any enrollment period by submitting a form provided or approved by the Company. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for coverage under the Policy.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents will take effect on the date agreed to by the Enrolling Group and the Company. Coverage is effective only if the Company receives any required Premium and a properly completed enrollment form within 31 days of the date you first become eligible.

Coverage for a Newly Eligible Dependent

You may make coverage changes during the year for any Dependent whose status as a Dependent is affected by a marriage, divorce, legal separation, annulment, birth, legal guardianship, placement for adoption or adoption, as required by federal law. In such cases you must submit the required contribution of coverage and a properly completed enrollment form within 31 days of the marriage, birth, placement for adoption or adoption. Otherwise, you will need to wait until the next enrollment period.

Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage shall take effect on the date of the event. Coverage is effective only if the Company receives any required Premium and is notified of the event within 31 days.

Coverage for Children of Noncustodial Parent

When a child has vision coverage through an insurer of a noncustodial parent, We will:

- A. provide information to the child's custodial parent(s) as may be necessary for the child to obtain benefits under the Policy;
- B. permit the child's custodial parent(s) or the Dentist with the custodial parent's approval, to submit claims for covered expenses without the approval of the noncustodial parent; and
- C. make payments on such claims directly to the child's custodial parent(s), to the Provider, or to the state Medicaid agency.

Coverage for Children under a Court or Administrative Order

When You are required by a Court or Administrative Order to provide vision insurance for a child when You do not have custody of the child, We will:

- A. permit You to enroll the child for vision insurance under the Policy without regard to any enrollment period restrictions; and
- B. add the child to the Policy for vision insurance, upon enrollment made by the child's custodial parent, by the state agency administering a Medicaid program, or by the state agency administering a child support enforcement program if You fail to enroll the child.

We will not add a child for vision insurance unless You are also insured by the Policy.

We will not terminate the child's vision insurance unless We are provided satisfactory written evidence that:

- A. the court or administrative order is no longer in effect;
- B. the child is or will be enrolled in a comparable dental Policy with another insurer that will take effect no later than the termination date from this Policy;
- C. the required premiums for the child are not paid by the premium due date;
- D. dependent insurance is no longer available under the Policy; or
- E. You are no longer insured by the Policy.

We will:

- A. provide information to the child's custodial parent(s) as may be necessary for the child to obtain benefits under the Policy;
- B. permit the child's custodial parent(s), or the provider with the custodial parents' approval, to submit claims for covered expenses without Your approval; and
- C. make payments on such claims directly to the child's custodial parent(s), to the provider, or to the state Medicaid agency.

Section 3: Termination Provisions

Termination of Coverage

A Covered Person's coverage, including coverage for Services rendered after the date of termination for conditions arising prior to the date of termination, will automatically terminate on the earliest of the dates specified below:

1. The date the entire Policy is terminated for the reasons specified in the Policy. The Enrolling Group is responsible for notifying the Subscriber of the termination of the Policy.
2. The last day of the month during which the Covered Person ceases to be an Eligible Person.
3. The date requested in such notice when the Company receives written notice from either the Subscriber or the Enrolling Group instructing the Company to terminate coverage of the Subscriber or any Covered Person.
4. The date the Subscriber is retired or pensioned under the Enrolling Group's plan, unless a specific coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, the Company will provide written notice of termination to the Subscriber:

5. The date specified by the Company that all coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided the Company with false material information. Such information may include, but is not limited to, information relating to residence, information relating to another person's eligibility for coverage or status as a Dependent. The Company has the right to rescind coverage back to the Policy Effective Date.
6. The date specified by the Company that coverage will terminate due to material violation of the terms of the Policy.
7. The date specified by the Company that the Covered Person's coverage will terminate because the Covered Person has committed acts of physical or verbal abuse that pose a threat to the Company's staff, a provider, or other Covered Persons.
8. The date specified by the Company that all coverage will terminate because the Covered Person permitted the use of his or her ID card by any unauthorized person or used another person's card.
9. The date specified by the Company that your coverage will terminate because the Subscriber failed to pay a required Premium.

If covered Services are in progress on the date which coverage terminates, such Services will be completed, except where termination is due to fraud, misrepresentation, material violation of the terms of the Policy, failure to pay required Premiums, or acts of physical or verbal abuse.

Reimbursement for Services

The Covered Person will be responsible for any claims paid by the Company when coverage was provided in error, except where that error was made by the Company.

Extended Coverage for Handicapped Dependent Children

Coverage of an unmarried Enrolled Dependent who is incapable of self-support because of mental retardation or physical handicap will be continued beyond the limiting age provided that:

- A. The Enrolled Dependent becomes so incapacitated prior to attainment of the limiting age;

- B. The Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance;
- C. Proof of such incapacity and dependence is furnished to the Company within 31 days of the date the Subscriber receives a request for such proof from the Company; and
- D. Payment of any required contribution for the Enrolled Dependent is continued.

Coverage will continue so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, the Company may reasonably require that the Enrolled Dependent be examined at the Company's expense by a physician designated by the Company. At reasonable intervals, the Company may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at the Company's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the request by the Company will result in the termination of the Enrolled Dependent's coverage under the Policy.

Section 4: Benefits

You will be provided with benefits for each of the listed Services as stated in the *Table of Benefits*. Your rights to benefits are subject to the terms, conditions, and exclusions of the Policy, including this *Certificate*, and any attached Amendments.

Obtaining Services

To find a Network Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Network Providers on the Internet at www.uhcspecialtybenefits.com.

You also may obtain Services from a non Network Provider. However, the amount of coverage may be reduced.

Foreign Services

Foreign Services will be treated as Non-Network benefits under this Policy. Payments will be made in U.S. currency and dispersed to the U.S. address of the Subscriber. The Company makes no guarantee on value of payment and will not protect against currency risk. Currency valuations for payment liability will be based on exchange rates published in the Wall Street Journal on the date the claim is processed.

Section 5: Benefit Descriptions

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Covered Person resides, to include:

1. A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.;
2. Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.);
3. Cover test at 20 feet and 16 inches (checks eye alignment);
4. Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception;
5. Pupil responses (neurological integrity);
6. External exam;
7. Internal exam;
8. Retinoscopy (when applicable) - objective refraction to determine lens power of corrective Subjective refraction – to determine lens power of corrective lenses;
9. Phorometry/Binocular testing - far and near: how well eyes work as a team;
10. Tests of accommodation and/or near point refraction: how well Covered Person sees at near point (reading, etc.);
11. Tonometry, when indicated: test pressure in eye (glaucoma check);
12. Ophthalmoscopic examination of the internal eye;
13. Confrontation visual fields;
14. Biomicroscopy;
15. Color vision testing;
16. Diagnosis/prognosis; and
17. Specific recommendations.

Post examination procedures will be performed only when materials are required.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames

A structure that contains eyeglasses lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Optional Lens Extras

Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, tinted lenses, polycarbonate lenses, transition lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromatic coating.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Necessary Contact Lenses

This benefit is available where a provider has determined a need for and has prescribed the service. Such determination will be made by the provider and not by us.

Contact lenses are necessary if the Covered Person has:

1. Keratoconus or irregular astigmatism;
2. Anisometropia of 3.50 diopters or more;
3. Post-cataract surgery without intraocular lens; or
4. Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.

Section 6: General Provisions

Legal Actions

No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed. No such action may be brought more than 3 years after the claim is required to be filed.

Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. No change will be made to the Policy unless it is made by an Amendment or a Rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, will be used to void this Policy after it has been in force for a period of 2 years.

Relationship Between Parties

The relationships between the Company and providers, and the relationship between the Company and the Enrolling Group, are solely contractual relationships between independent contractors. Providers and the Enrolling Group are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or of the Enrolling Group.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided by it to any Covered Person. The Enrolling Group is solely responsible for enrollment and coverage classification changes (including termination of a Covered Person's coverage through the Company) and for the timely payment of the Policy Charge.

Assignment of Benefits

No assignment of the benefits or of payment for reimbursement is binding unless agreed to in writing. Such agreement is not valid until approved by us.

Clerical Error

If a clerical error or other mistake occurs, that error will not deprive you of coverage under the Policy. A clerical error also does not create a right to benefits.

Notice

When the Company provides written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons.

Workers' Compensation Not Affected

The coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Conformity with Statutes

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Waiver/Estoppel

Nothing in the Policy, *Certificate* or *Table of Benefits* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, *Certificate* or *Table of Benefits*, or to exercise any option which is herein provided, shall in no way be construed to be a waiver of such provision of the Policy, *Certificate* or *Table of Benefits*.

Headings

The headings, titles and any table of contents contained in the Policy, *Certificate* or *Table of Benefits* are for reference purposes only and shall not in any way affect the meaning or interpretation of the Policy, *Certificate* or *Table of Benefits*.

Unenforceable Provisions

If any provision of the Policy, *Certificate* or *Table of Benefits* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate* or *Table of Benefits* to the greatest extent legally permissible.

Section 7: Claims

Notice of Claim

Notice of claim as determined by us must be given to us within 365 days of the date such loss begins. The notice must be given with sufficient information to identify the Covered Person. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the notice must be given as soon as reasonably possible.

Payment of Claims

When obtaining Services from a Network Provider, you will be required to pay a Copayment and any charges not covered by the Policy to your Provider. When obtaining Services from a Network Provider, you will not be required to submit a claim form.

When obtaining Services from a non-Network Provider, you will be required to pay all billed charges to your provider. You may then obtain reimbursement from us for the covered portion of Services.

Reimbursement

To file a claim for reimbursement for Services rendered by a non-Network Provider, or for Services covered as reimbursements (whether or not rendered by a Network Provider or a non-Network Provider), provide the following information on claim form acceptable to the Company:

1. Your itemized receipts;
2. Subscriber name;
3. Subscriber's identification number;
4. Patient name; and
5. Patient date of birth.

Submit the above information to us:

By mail:

Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Reimbursements are payable in accordance with any state prompt pay requirements after the Company receives acceptable proof of loss.

Medicaid Benefit. Benefits are payable to the Human Services Department when:

- A. Human Services are paying benefits for a Covered Person under the state's Medicaid program under Title XIX of the federal Social Security Act, 42 U.S.C. 1396;
- B. Payment for services have been made by the Human Services Department to the Medicaid provider; and

C. We are notified that a Covered Person has received benefits under the Medicaid program.

Examination of Covered Persons

In the event of a question or dispute concerning coverage for vision Services, the Company may reasonably require that a Covered Person be examined at the Company's expense by a Network Provider acceptable to the Company.

Section 8: Complaint Procedures

Complaint Resolution

If you have a concern or question regarding the provision of Services or benefits under the Policy, you should contact the Company's customer service department. Customer service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A customer service representative will return your call. If you would rather send your concern to us in writing at this point, the Company's authorized representative can provide you with the appropriate address.

If the customer service representative cannot resolve the issue to your satisfaction over the phone, he or she can provide you with the appropriate address to submit a written complaint. We will notify you of our decision regarding your complaint within 30 days of receiving it.

If you disagree with our decision after having submitted a written complaint, you can ask us in writing to formally reconsider your complaint. If your complaint relates to a claim for payment, your request should include:

The patient's name and identification number.

The date(s) of service(s).

The provider's name.

The reason you believe the claim should be paid.

Any new information to support your request for claim payment.

We will notify you of our decision regarding our reconsideration of your complaint within 60 days of receiving it. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Complaint Hearing

If you request a hearing, we will appoint a committee to resolve or recommend the resolution of your complaint. If your complaint is related to clinical matters, the Company may consult with, or seek the participation of, medical and/or vision experts as part of the complaint resolution process.

The committee will advise you of the date and place of your complaint hearing. The hearing will be held within 60 days following the receipt of your request by the Company, at which time the committee will review testimony, explanation or other information that it decides is necessary for a fair review of the complaint.

We will send you written notification of the committee's decision within 30 days of the conclusion of the hearing. If you are not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Section 9: Subrogation

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. The Company will be subrogated to and will succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and benefits provided by the Company to you from: (i) third parties, including any person alleged to have caused you to suffer injuries or damages; (ii) your employer; or (iii) any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties"). You agree to assign to the Company all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits provided by the Company, plus reasonable costs of collection.

You will cooperate with the Company in protecting the Company's legal rights to subrogation and reimbursement, and acknowledge that the Company's rights will be considered as the first priority claim against Third Parties, to be paid before any other claims by you are paid. You will do nothing to prejudice the Company's rights under this provision, either before or after the need for services or benefits under the Policy. The Company may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in your name. For the reasonable value of services provided under the Policy, the Company may collect, at its option, amounts from the proceeds of any settlement (whether before or after any determination of liability) or judgment that may be recovered by you or your legal representative, regardless of whether or not you have been fully compensated. You will hold in trust any proceeds of settlement or judgment for the benefit of the Company under these subrogation provisions and the Company will be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you. You will not accept any settlement that does not fully compensate or reimburse the Company without the written approval of the Company. You agree to execute and deliver such documents (including a written confirmation of assignment, and consent to release vision records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as may be reasonably requested by the Company.

Section 10: Refund of Expenses

Refund of Overpayments

If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

- A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- B. All or some of the payment made by the Company exceeded the benefits under the Policy; or
- C. All or some of the payment was made in error.

The refund equals the amount the Company paid in excess of the amount it should have paid under the Policy.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Refund of Benefits Paid by Third-Parties

If the Company pays benefits for expenses incurred on account of a Covered Person, the Subscriber or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than the Policy as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under the Policy. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Enrolling Group. The reduction will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Section 11: Exclusions

The following Services and materials are excluded from coverage under the Policy:

1. Non-prescription items (e.g. Plano lenses).
2. Services that the Covered Person, without cost, obtains from any governmental organization or program.
3. Services for which the Covered Person may be compensated under Worker's Compensation Law, or other similar employer liability law.
4. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.
5. Medical or surgical treatment for eye disease, which requires the services of a physician.
6. Replacement or repair of lenses and/or frames that have been lost or broken.
7. Optional Lens Extras not listed in the *Table of Benefits*.
8. Missed appointment charges.
9. Applicable sales tax charged on Services.
10. Services that are not specifically covered by the Policy.
11. Procedures that are considered to be Experimental, Investigational or Unproven. 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 coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

Group Vision Care Table of Benefits

Third Party Administrator: Spectera, Inc.

Claim Administrator: United HealthCare Insurance Company, 6220 Old Dobbin Lane, Columbia, MD 21045. Telephone No. 1-800-839-3242

The following Services will be covered in full, subject to a Copayment, when obtained from Network Providers.

When obtaining these Services from a Network Provider, you will be required to pay a Copayment at the time of service for certain Services. The amount of Copayment that a Network Provider will charge is as noted in the column "Copayment at a Network Provider" in the chart below.

When obtaining these Services from a non-Network Provider, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts noted in the column "Non-Network Benefit" in the chart below.

SERVICE	FREQUENCY OF SERVICE	COPAYMENT AT A NETWORK PROVIDER	NON-NETWORK BENEFIT
Routine Vision Examination	Once every 12 months	\$10.00	Up to \$40.00
Eyeglass Frames	Once every 12 months ¹	\$10.00 ² from the Covered Eyeglass Frames Selection ³	Up to \$45.00
Eyeglass Lenses	Once every 12 months ¹		
• Single Vision		\$10.00 ²	Up to \$40.00
• Bifocal		\$10.00 ²	Up to \$60.00
• Trifocal		\$10.00 ²	Up to \$80.00
• Lenticular		\$10.00 ²	Up to \$80.00
Contact Lenses	Once every 12 months ¹	\$10.00 from the Covered Contact Lens Selection ⁴	Up to \$105.00
• Necessary		\$10.00	Up to \$210.00

Optional Lens Extras:

- Eyeglass Lenses: The following Optional Lens Extras are covered in full:
 - Standard scratch-resistant coating

¹You are eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you select more than one of these Services, only one Service will be covered.

²If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Network Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

³You may purchase from your Network Provider Eyeglass Frames that are outside of the Covered Eyeglass Frames Selection. Non-selection Eyeglass Frames will receive an allowance. The Eyeglass Frame allowance will be \$50.00 wholesale or \$130.00 retail, depending upon the type of Network Provider selected. No Copayment will apply to non-selection Eyeglass Frames.

⁴You may purchase from your Network Provider Contact Lenses that are outside of the Covered Contact Lens Selection. Non-selection Contact Lenses will receive an allowance of \$105.00. No Copayment will apply to non-selection Contact Lenses.

UNITEDHEALTHCARE VISION

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective: April 14, 2003

We* are required by law to protect the privacy of your health information. We are also required to send you this notice which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that related to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our web site www.uhcspecialtybenefits.com.

*For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities: ACN Group of California, Inc.; All Savers Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, In.; Dental Benefit Providers of California, Inc.; Dental benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Dental Benefit Providers of New Jersey, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; Investors Guaranty Life Insurance Company; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Nevada Pacific Dental, Inc.; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Optimum Choice, Inc. of Pennsylvania; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; Pacific Union Dental, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc., UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; and U.S. Behavioral Health Plan, California.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **For Payment** of premiums due us and to process claims for health care services you receive.
- **For Treatment.** We may disclose health information to your doctors or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws of job-related injuries.

- **Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

If none of the above reasons apply, **then we must get your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, refer to "Exercising Your Rights" on page 4 of this notice.

Highly Confidential Information

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

Attached to this notice is a *Summary of State Laws on Use and Disclosure of Certain Types of Medical Information*.

What Are Your Rights

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.

- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, www.uhcspecialtybenefits.com

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

United Healthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

You may also notify the *Secretary of the U.S. Department of Health and Human Services* of your complaint. We will not take any action against you for filing a complaint.

Financial Information Privacy Notice

We (including our affiliates listed at the bottom of this page)* are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

**For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group, Inc.; ACN Group IPA of New York, Inc.; Alliance Recovery Services, LLC; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Continental Plan Services, Inc.; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG Resource Options, LLC; Definity Health Corporation; Definity Health of New York, Inc.; Dental Benefit Providers, Inc.; Dental Insurance Company of America; Exante Bank, Inc.; Fidelity Benefit Administrators, Inc.; HealthAllies, Inc.; IBA Self Funded Group, Inc.; Illinois Pacific Dental, Inc.; Lifemark Corporation; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; NPD Dental Services; NPD Insurance Company, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Pacific Dental Benefits; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; Uniprise, Inc.; United Behavioral Health of New York, I.P.A., Inc.; UnitedHealth Advisors, LLC; United HealthCare Services, Inc.; UnitedHealthcare Services Company of the River Valley, Inc.; United HealthCare Service LLC; United Medical Resources, Inc.*

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

This information is intended to provide an overview of state laws that are more stringent than the federal *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules* with respect to the use or disclosure of protected health information in the categories listed below.

Sexually Transmitted Diseases and Reproductive Health	
Disclosure of sexually transmitted diseases and reproductive health related information may be: (1) limited to specified circumstances; and/or (2) restricted by the patient.	HI, MS, NM, NY, NC, OK, WA, VA
Disclosure of sexually transmitted diseases and reproductive health information must be accompanied by a written statement meeting certain requirements.	NM
There are specific requirements that must be followed when an insurer uses or requests sexually transmitted disease tests or reproductive health information for insurance or underwriting purposes.	MS
Alcohol and Drug Abuse	
Disclosure of alcohol and drug abuse information may be: (1) limited to specified circumstances; (2) restricted by the patient; and/or (3) prohibited under certain circumstances.	GA, HI, KY, MA, NH, OK, VA, WA, WI
A specific written statement must accompany any alcohol and drug abuse information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests drug and alcohol tests or information for insurance or underwriting purposes.	KY, VA
Genetic Information	
An authorization is required for each disclosure of genetic information.	CA, HI, KY, LA, RI, TN
Genetic information may be disclosed only under specific circumstances.	AZ, CO, FL, GA, HI, IL, MD, MA, MO, NV, NH, NJ, NM, NY, OR, TX, VT
Restrictions apply to (1) the use; and/or (2) the retention of genetic information.	CO, GA, IL, NV, NJ, NM, OR, VT, WY
Specific requirements must be followed when an insurer uses or requests a genetic test for insurance or underwriting purposes.	FL, IL, IN, LA, NV, WY

HIV/AIDS	
Disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances; and/or (2) restricted by the patient.	AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, ME, MA, MI, NH, NJ, NM, NY, NC, OH, OK, OR, PA, TX, UT, VT, VA, WA, WV, WI
A specific written statement must accompany any HIV/AIDS related information.	AZ, CT, KY, NM, OR, PA, WV
Certain restrictions apply to the retention of HIV/AIDS related information.	MA, NH
Specific requirements must be followed when an insurer uses or requests an HIV/AIDS test for insurance or underwriting purposes.	AR, DE, FL, IA, MA, NH, PA, UT, VA, VT, WA, WV
Improper disclosure may be subject to penalties.	DE
Disclosure to the individual and/or designated physician may be required.	MA, NH
Mental Health	
Disclosure of mental health information may be: (1) limited to specific circumstances; (2) restricted by the patient; and/or (3) prohibited or prevented under certain circumstances.	AL, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, ME, MA, MD, MI, MN, NM, NY, OK, PA, TN, TX, VT, VA, WA, WV, WI
A specific written statement must accompany any mental health information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests mental health information for insurance or underwriting purposes.	IA, KY, ME, MA, NM, TN, VA
Child or Adult Abuse	
Abuse related information may only be disclosed under specific circumstances.	AL, LA, NM, TN, UT, VA, WI

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your enrolling group's plan administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the policy on the day before a qualifying event:

- A subscriber.
- A subscriber's enrolled dependent, including with respect to the subscriber's children, a child born to or placed for adoption with the subscriber during a period of continuation coverage under federal law.
- A subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

- A. Termination of the subscriber from employment with the enrolling group, for any reason other than gross misconduct.
- B. Reduction in the subscriber's hours of employment.

With respect to a subscriber's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

- A. Termination of the subscriber from employment with the enrolling group, for any reason other than the subscriber's gross misconduct.
- B. Reduction in the subscriber's hours of employment.
- C. Death of the subscriber.
- D. Divorce or legal separation of the subscriber.
- E. Loss of eligibility by an enrolled dependent who is a child.
- F. Entitlement of the subscriber to Medicare benefits.
- G. The enrolling group filing for bankruptcy, under Title 11, United States Code. This is also a qualifying event for any retired subscriber and his or her enrolled dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator within 60 days of the latest of the date of the following events:

- The subscriber's divorce or legal separation, or an enrolled dependent's loss of eligibility as an enrolled dependent.
- The date the Qualified Beneficiary would lose coverage under the policy.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The subscriber or other Qualified Beneficiary must also notify the enrolling group's plan administrator when a second qualifying event occurs, which may extend continuation coverage.

If the subscriber or other Qualified Beneficiary fails to notify the enrolling group's plan administrator of these events within the 60 day period, the plan administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a subscriber is continuing coverage under federal law, the subscriber must notify the enrolling group's plan administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The subscriber or other Qualified Beneficiary must notify the enrolling group's plan administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the enrolling group's plan administrator. The contents of the notice must be such that the plan administrator is able to determine the covered employee and Qualified Beneficiary or beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the subscriber or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the enrolling group's plan administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the plan administrator.

The Qualified Beneficiary's initial premium due to the plan administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If you qualify or may qualify for assistance under the Trade Act of 1974, contact the enrolling group for additional information. You must contact the enrolling group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that plan coverage was lost but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the policy will end on the earliest of the following dates:

- A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

- Notice of such disability must be provided within the latest of 60 days after:
 - the determination of the disability; or
 - the date of the qualifying event; or
 - the date the Qualified Beneficiary would lose coverage under the policy; and
 - in no event later than the end of the first eighteen months.
- The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
- If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an enrolled dependent whose coverage ended because of the death of the subscriber, divorce or legal separation of the subscriber, or loss of eligibility by an enrolled dependent who is a child (i.e. qualifying events C., D., or E.).
- C. With respect to Qualified Beneficiaries, and to the extent that the subscriber was entitled to Medicare prior to the qualifying event:
- Eighteen months from the date of the subscriber's Medicare entitlement; or
 - Thirty-six months from the date of the subscriber's Medicare entitlement, if a second qualifying event (that was due to either the subscriber's termination of employment or the subscriber's work hours being reduced) occurs prior to the expiration of the eighteen months.
- D. With respect to Qualified Beneficiaries, and to the extent that the subscriber became entitled to Medicare subsequent to the qualifying event:

- Thirty-six months from the date of the subscriber's termination from employment or work hours being reduced (first qualifying event) if:
 - The subscriber's Medicare entitlement occurs within the eighteen month continuation period; and
 - If, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.
- E. The date coverage terminates under the policy for failure to make timely payment of the premium.
- F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the enrolling group filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the enrolling group filed for bankruptcy, (i.e. qualifying event G.) and the retired subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the subscriber's death.
- H. The date the entire policy ends.
- I. The date coverage would otherwise terminate under the policy.

Benefit Summary Brochure

Customer Service: **800-638-3120**Provider Locator: **800-839-3242****www.myuhcvision.com**

UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating¹ and the frame, or contact lenses in lieu of eye glasses.

Rates	
Employee	\$7.72 Monthly
Employee + Spouse	\$15.66 Monthly
Employee + Child(ren)	\$16.40 Monthly
Employee + Family	\$20.76 Monthly
Copays for in-network services	
Exam	\$10.00
Materials	\$10.00
Benefit frequency	
Comprehensive Exam	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 12 months
Contact Lenses in Lieu of Eye Glasses	Once every 12 months
Frame benefit	
Private Practice Provider	\$130.00 retail frame allowance
Retail Chain Provider	\$130.00 retail frame allowance
Lens options	
Standard scratch-resistant coating – covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)	
Contact lens benefit	
<p>Covered-in-full elective contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full (after copay). If you choose disposable contacts, up to 4 boxes are included when obtained from a network provider.</p> <p>All other elective contact lenses A \$105.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts.</p> <p>Necessary contact lenses³ Covered in full after applicable copay.</p>	
Out-of-network reimbursements up to (Copays do not apply)	
Exam	\$40.00
Frames	\$45.00
Single Vision Lenses	\$40.00
Bifocal Lenses	\$60.00
Trifocal Lenses	\$80.00
Lenticular Lenses	\$80.00
Elective Contacts in Lieu of Eye Glasses ²	\$105.00
Necessary Contacts in Lieu of Eye Glasses ³	\$210.00
Laser vision benefit	
UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at LasikPlus locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com .	

Sample Illustration of Savings

Cost	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Annual Premium	\$92.64	\$187.92	\$196.80	\$249.12
Approx. Pre-Tax Savings (20%) ⁴	\$18.53	\$37.58	\$39.36	\$49.82
Annual Tax-Adjusted Premium	\$74.11	\$150.34	\$157.44	\$199.30
Plus Copays	\$20.00	\$40.00	\$60.00	\$80.00
Total Cost to Employee	\$94.11	\$190.34	\$217.44	\$279.30

Exam and Materials Covered by UnitedHealthcare Vision Plan	Estimated Cost Without a Vision Plan ⁵	Less Employee Cost	Total Savings with UnitedHealthcare Vision
Employee Exam, Single Vision & Covered-in-Full Frames	\$275.00	\$94.11	\$180.89
Employee + Spouse Exam, Single Vision & Covered-in-Full Frames	\$550.00	\$190.34	\$359.66
Employee + Child(ren)⁶ Exam, Single Vision & Covered-in-Full Frames	\$825.00	\$217.44	\$607.56
Employee + Family⁷ Exam, Single Vision & Covered-in-Full Frames	\$1,100.00	\$279.30	\$820.70

¹ On all orders processed through a company owned and contracted Lab network.

² The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.

³ Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

⁴ Actual tax savings will depend upon your individual tax bracket.

⁵ Approximate retail value illustrated: Exam & Refraction (\$65), Single Vision Lenses (\$80), and Frames (\$130). Average retail costs may vary by provider.

⁶ For purposes of this calculation, Employee + Child(ren) is calculated with three (3) members.

⁷ For purposes of this sample calculation, Employee + Family is calculated with four (4) members.

Important to Remember:

- Benefit frequency based on last date of service.
- Your \$105.00 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is \$30, you will have \$75.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- Medically necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming how much of a reimbursement you can expect to receive before you purchase such contacts.
- You can log on to our website to print off your personalized ID card. An ID card is not required for service, but is available as a convenience to you should you wish to have an ID card to take to your appointment.
- **Out-of-Network Reimbursement, when applicable:** Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UnitedHealthcare Vision Attn. Claims Department P.O. Box 30978 Salt Lake City, UT 84130 FAX: 248.733.6060.
- UnitedHealthcare Vision offers an Additional Materials Discount Program. At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations.

The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06 and associated COC form number VCOO.INT.06.TX.



Vision Benefit Card

UnitedHealthcare Vision®

CITY OF SANTA FE

Exam	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 12 months
Contacts*	Once every 12 months
*(in lieu of lenses & frames)	

Exam Copay	\$10.00
Materials Copay	\$10.00

To print a personalized ID card, please logon to our website and select 'Print ID card' from the member benefits page.

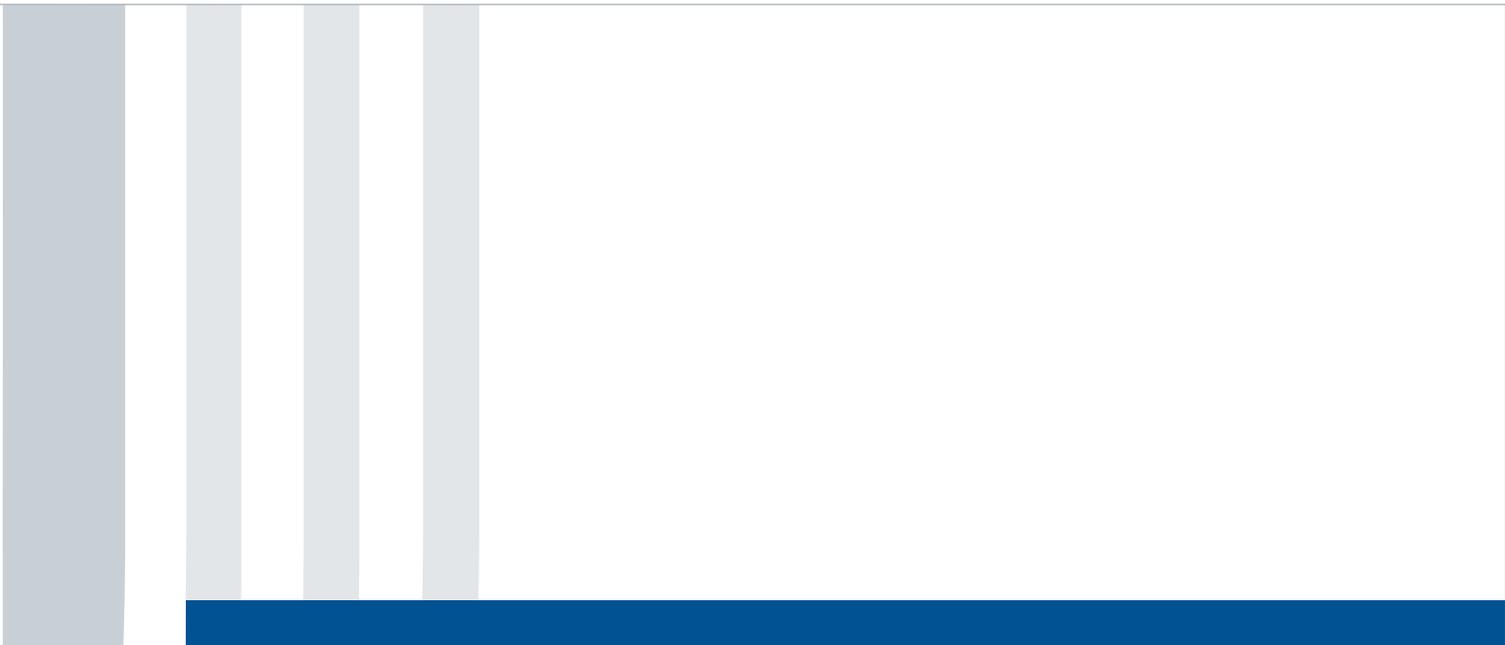
UnitedHealthcare Vision®

www.myuhcvision.com

Customer Service: 800-638-3120

TDD for Hearing Impaired: 1.800.524.3157

Provider Locator: 1.800.839.3242



Renewal Presentation for
City Of Santa Fe - Sold

Issued on: June 5, 2012



Vision Renewal & Rates

Customer Name: City Of Santa Fe
Client ID: G9GR
Policy Number: 712215

Situs State: NM
Renewal Effective Date: 7/1/2012

Vision Services*		Renewal V1005	
Legal Entity		UnitedHealthcare Insurance Company	
Exams/Lenses/Frames		12/12/12	
Plan Options			
Contribution		100% Employee Paid	
Exam Co-pay		\$10	
Material Co-pay		\$10	
Benefits		In-Network	Out-of-Network
Eye Examination			
Exam		100%	Up to \$40
Lenses			
Single Vision		100%	Up to \$40
Lined Bifocal		100%	Up to \$60
Lined Trifocal		100%	Up to \$80
Lenticular		100%	Up to \$80
Frames*			
Retail Frame Allowance		Up to \$130	Up to \$45
30% Discount on Frame Overage*		Incl	N/A
Elective Contact Lenses**			
Covered-in-Full Selection Contacts		4 Boxes	Up to \$105
Non-Selection Contacts		Up to \$105	Up to \$105
Necessary Contact Lenses		100%	Up to \$210
Lens Options (In Network Only)			
Lens Options Covered-in-Full		See Below	N/A
Rates			
	Enrollment	Current	Renewal
Employee	137	\$7.72	\$7.72
Employee + Spouse	106	\$15.66	\$15.66
Employee + Child(ren)	54	\$16.40	\$16.40
Employee + Family	155	\$20.76	\$20.76
Monthly Premium	452	\$6,821.00	\$6,821.00
Annual Premium		\$81,852.00	\$81,852.00
Renewal Action		0.0%	
Commission		0.0%	
Rate Guarantee / Rate End Date		36 Months	6/30/2015

- ✓ United Healthcare reserves the right to adjust the above rates should enrollment fluctuate by +/- 10%.
- ✓ Rates assume no changes in legislation or regulation that affects the benefits payable, eligibility or contract.
- ✓ Eligible Dependent children covered to age 26.
- ✓ For any frame costing more than the allowance, the member only pays the difference between the retail cost of the frame and the allowance, plus any applicable copay.
- ✓ Rates listed above are not included in quoted Medical rates (if applicable).
- ✓ Frame Benefit: All wholesale frames less than our allowance are covered in-full at private practice providers.
- ✓ Voluntary plan rates are based on 0% Employer contribution level and maintaining employee participation +/-10%.
- ✓ Lens Options: Scratch Coating.

*** Frame Benefit**

- ✓ Plan participants receive a frame allowance toward the retail cost of frames purchased at any in-network provider.
- ✓ Frames less than the allowance require no additional out of pocket for the member, other than applicable copay.
- ✓ If the member chooses a frame that exceeds their allowance, the member only pays the difference, plus any applicable copay.
- ✓ As an added value many of our providers offer a 30% discount on the balance, or frame overage, if the member exceeds their allowance.
- ✓ Frame discounts do not apply when prohibited by the manufacturer.

**** Contact Lens Benefit**

- ✓ When members visit a network provider, our contact lens benefit covers in full (after applicable copay) the fitting/and evaluation fees, many popular contact lenses (including disposables), and up to two follow-up visits.
- ✓ Members who select contact lenses outside of the covered-in-full selection will receive an allowance towards the fitting/and evaluation fees and purchase of the contact lenses (in this case the materials copay would not apply).

Other Member Benefits

- ✓ 20% discount on additional materials not covered-in-full (at participating providers).
- ✓ Discounts on lens options not covered-in-full (at participating providers).
- ✓ Access to discounts on laser vision correction.
- ✓ Ability to print an online ID card, find a provider, access plan information and more by visiting www.myuhcvision.com



This proposal is valid for 90 days from the issued date, unless otherwise noted within this document.

Brokers and agents may receive commissions, bonuses and other compensation for selling the products presented in this proposal. The cost of this compensation may be directly or indirectly reflected in the premium or fees for those products. Contact your broker and/or agent if you have questions regarding their compensation relating to products in this proposal.

This proposal is subject to negotiation and execution of a written agreement, which will supersede the proposal contents. This proposal does not constitute an agreement, and is based on assumptions made from the written information in our possession and provided by you. We retain the right to modify our proposal if the information upon which this proposal is based is changed or is supplemented.

We consider much of the information contained in the proposal to be proprietary or otherwise confidential, and are releasing this proposal to you on the understanding that you and your representatives will only use it, and any data included in the proposal, for the specific purpose of evaluating its content. If this is not consistent with your understanding, please notify us before reviewing the proposal.

In addition, by accepting and reviewing the contents of this proposal, you and your agents or other designees agree, to the extent permitted by law, that certain information contained herein, or other information provided to you in connection with this proposal response or associated request for proposal (RFP), is proprietary and/or confidential to UnitedHealthcare, and its related entities, and may not be copied, used, distributed or disclosed without prior written consent from an authorized representative of UnitedHealthcare, other than is necessary to evaluate this proposal.

UnitedHealthcare Vision
UnitedHealthcare Insurance Company

Policy

For

City of Santa Fe

GROUP NUMBER: 712215

Group Vision Care Insurance Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

1-800-638-3120

A Limited Benefit Policy

Issued To: City of Santa Fe ("Enrolling Group")
Policy Number: 712215
Policy Effective Date: July 1, 2011
Policy Anniversary Date: July 1

UnitedHealthcare Insurance Company agrees to pay the benefits and provide the other rights set forth in the Policy, in consideration of the Enrolling Group's application and payment of Policy Charges.

Upon receipt of the Enrolling Group's application and payment of the required Policy Charges, this Policy is deemed executed.

As used in this Policy, the words "we", "us", "our", and "the Company" refer to UnitedHealthcare Insurance Company.

The Policy will take effect as of the Policy Effective Date set forth above, provided that it has been signed by an officer of the Company, and the Enrolling Group has signed the application.

This Policy replaces and supersedes any previous agreements relating to the coverage of vision services between the Enrolling Group and the Company. The terms and conditions of this Policy will in turn be superseded by those of any subsequent agreements relating to the coverage of vision services between the Enrolling Group and the Company.

The Company will not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. The Company will not be responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

This Policy will become effective at 12:01 a.m. at the Enrolling Group's address on the Policy Effective Date, and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided herein. When the Policy is terminated as provided for in the *Termination of the Entire Policy* section, this Policy and all coverage under this Policy will end at 12:00 midnight on the date of termination.

This Policy is delivered in and governed by the laws of the State of New Mexico.

Issued By:

UNITEDHEALTHCARE INSURANCE COMPANY



Allen J. Sorbo, President

Group Vision Care Insurance Policy Table of Contents

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Definitions

Grace Period - A period of time following the Payment Due Date during which the Enrolling Group may pay the due Policy Charge without penalty under the Policy.

Payment Due Date - The date on which the Enrolling Group's payment of a Policy Charge is due.

Policy Charge - An amount owed by the Enrolling Group to the Company for coverage of Covered Persons enrolled in the Enrolling Group's benefit plan, based on the number of Subscribers in each coverage classification at the time of calculation and at the Premiums then in effect.

Policy Effective Date - The date on which the Enrolling Group's coverage under the plan becomes effective.

All other terms used in this Policy have the same meaning given those terms in the *Certificate of Coverage* ("*Certificate*"), unless otherwise specifically defined in this Policy.

General Provisions

Entire Contract

This Policy, the Enrolling Group's Application, the *Certificate(s)*, *Table(s) of Benefits* and any amendments, riders, endorsements, and individual enrollment forms will constitute the entire contract. Any amendments, riders, endorsements, *Certificate(s)* or *Table(s) of Benefits* issued after the Policy Effective Date will be made a part of the Policy.

Amendments and Alterations

Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. No change will be made to the Policy unless it is made by an Amendment or a Rider that is signed by an officer of the Company. No agent has authority to change the Policy or to waive any of its provisions.

Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, will be used to void this Policy after it has been in force for a period of 2 years.

Jurisdiction

The Policy has been issued and delivered in the Governing Jurisdiction shown on the first page of the Policy. The laws of such jurisdiction will govern its execution, performance and enforcement. Any provision of the Policy that is in conflict with such laws will be deemed amended to meet the minimum requirements of such laws.

Waiver/Estoppel

Nothing in the Policy, *Certificate* or *Table of Benefits* is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy,

Certificate or *Table of Benefits* or to exercise any option which is herein provided, will in no way be construed to be a waiver of such provision of the Policy, *Certificate* or *Table of Benefits*.

Relationship Between Parties

The relationships between the Company and providers, and the relationship between the Company and the Enrolling Group, are solely contractual relationships between independent contractors. Providers and the Enrolling Group are not agents or employees of the Company, nor is the Company or any employee of the Company an agent or employee of providers or of the Enrolling Group.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided by it to any Covered Person. The Enrolling Group is solely responsible for enrollment and coverage classification changes (including termination of a Covered Person's coverage through the Company) and for the timely payment of the Policy Charge.

Workers' Compensation Not Affected

The coverage provided under this Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Headings

The headings, titles and any table of contents contained in the Policy, *Certificate* or *Table of Benefits* are for reference purposes only and will not in any way affect the meaning or interpretation of the Policy, *Certificate* or *Table of Benefits*.

Unenforceable Provisions

If any provision of the Policy, *Certificate* or *Table of Benefits* is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect and the illegal or unenforceable provision will be modified so as to conform to the original intent of the Policy, *Certificate* or *Table of Benefits* to the greatest extent legally permissible.

Administration

Notices

All notices or other communications required or permitted under this Policy will be in writing and will be delivered personally, by commercial overnight delivery service, or by registered or certified mail, return receipt requested, and will be deemed received: upon receipt (or the first business day after receipt, if received after business hours) in the case of personal delivery; three business days after the date of mailing in the case of certified or registered mail; and one business day after sending if delivered by overnight delivery service, addressed as follows:

If to the Company:

United HealthCare Insurance Company

6220 Old Dobbin Lane

Columbia, MD 21045

Attention: Account Management Services

With a copy to the Legal Department

If to the Enrolling Group:

To the mailing address on file with the Company.

A party may change the address at which it elects to receive any notice provided under this Policy by advising the other party of such change in accordance with this section.

Certificates

The Company will issue *Certificate(s)*, *Table(s) of Benefits* and any attachments to the Enrolling Group, in the format agreed upon by the Enrolling Group and the Company, for delivery to each covered Subscriber. The *Certificate*, *Table of Benefits* and any attachments will show all the benefits and provisions of the Policy.

Records

The Enrolling Group will furnish the Company with all information and proofs that the Company may reasonably require with regard to any matters pertaining to this Policy. The Company may at any reasonable time inspect all documents furnished to the Enrolling Group by an individual in connection with the coverage and any other records pertinent to the coverage under this Policy.

During and after the termination of the Policy, the Company and its related entities may use and transfer the information gathered under the Policy for research and analytic purposes.

Administrative Services

The services necessary to administer this Policy and the coverage provided under it will be provided in accordance with the Company's or its designee's standard administrative procedures. If the Enrolling Group requests that such administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group will pay for such services or reports at the Company's or its designee's then-current charges for such services or reports.

Examination of Covered Persons

In the event of a question or dispute concerning coverage for vision Services, the Company may reasonably require that a Covered Person be examined at the Company's expense by a Network Provider acceptable to the Company.

Information to be Provided by the Enrolling Group

The Enrolling Group will provide, with each Premium payment, a statement showing the number of persons enrolled for coverage during the time period. We will be permitted access to the Enrolling Group's records during reasonable business hours for the purpose of verifying such information.

Premium Rates and Policy Charge

Premium Rates

Premiums will be charged based upon the number of Subscribers enrolling in each coverage classification. The Premium rate in effect will be as indicated in Exhibit 1. The Company may change Premium rates pursuant to the section titled *Change in Premium Rates*.

Adjustments to the Policy Charge

Retroactive adjustments may be made for any additions or terminations of Subscribers or changes in coverage classification not reflected in the Company's records at the time the Policy Charge is calculated by the Company. However, no retroactive credit will be granted for any change occurring more than 60 days prior to the date the Company received notification of the change from the Enrolling Group, nor will retroactive credit be granted for any calendar month in which a Subscriber has received vision Services.

The Enrolling Group will notify the Company in writing within 30 days of the Effective Date of enrollments, terminations or other changes; provided, however, that the Enrolling Group will notify the Company in writing each month of any changes in the coverage classification of any Subscriber.

In the event there is any increase in premium tax, guarantee or uninsured fund assessment or other governmental charges relating to or calculated in regard to Premium such increase will be automatically added to the Premium.

Payment of the Policy Charge

The Enrolling Group will pay the Policy Charge to the Company or to the Company's agent on the Payment Due Date. The first Payment Due Date will be the Effective Date of the coverage. Each subsequent Payment Due Date will coincide with the first day of each succeeding calendar month for coverage during that month. We will determine the amount of any adjustment for coverage for a period of less than one (1) calendar month. The entire amount of the applicable Policy Charge will be paid when due. We are not obligated to accept or apply any Policy Charge paid which is less than the entire amount due for any period. Policy Charge payments will be credited first to any past due and unpaid Policy Charges, in the order in which due.

A late payment charge will be assessed for any Policy Charge not received by the last day of the Grace Period. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge.

The Enrolling Group will reimburse the Company for attorney's fees and any other costs related to collecting delinquent Policy Charges.

Grace Period

We will allow the Enrolling Group a Grace Period of 31 days for any Premium due after the first Premium. During the Grace Period, the coverage will remain in effect provided the full premium is paid before the end of the Grace Period. Should a premium otherwise due, not be paid during the Grace Period, the Policy will terminate without further notice as of 12:00 midnight on the last day for which premiums were paid.

Change in Premium Rates

The Company reserves the right to change the schedule of rates for Premiums, after a 60 day prior written notice on any premium due date. The Company also reserves the right to change the schedule of rates for Premiums, retroactive to the Effective Date, if a material misrepresentation has resulted in a lower schedule of rates. However, the Company may at its option limit future rate increases by agreement with the Enrolling Group.

Clerical Errors

Clerical errors will not deprive any individual of coverage under this Policy or create a right to benefits. Failure to report the termination of coverage will not continue such coverage beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, no such adjustment in Premiums

or coverage will be granted by the Company to the Enrolling Group for more than 60 days of coverage prior to the date the Company received notification of such clerical error.

Termination

Termination of the Entire Policy

This Policy and all coverage under this Policy will automatically terminate on the earliest of the dates specified below:

1. At the Company's option, retroactive to the last paid date of coverage, if the Grace Period expires and any Policy Charge remains unpaid.
2. On the date specified by the Company, when participation in the plan falls below 10 Subscribers.
3. On the date specified by the Enrolling Group, with at least 60 days prior written notice to the Company that this Policy will be terminated.
4. On the date specified by the Company, in written notice to the Enrolling Group, that this Policy will be terminated because the Enrolling Group provided the Company with false information material to the execution of this Policy or to the provision of coverage under this Policy. The Company has the right to rescind this Policy back to the Policy Effective Date.
5. On the date specified by the Company, with at least 90 days prior written notice to the Enrolling Group, that this Policy will be terminated because the Company will no longer renew or issue this particular type of group vision benefit plan within the applicable market.
6. On the date specified by the Company, with at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy will be terminated because the Company will no longer renew or issue any group vision benefit plan within the applicable market.

Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group will be and will remain liable to the Company for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata fee for any period this Policy was in force during the Grace Period, if any, preceding the termination.

Exhibit 1 to Group Vision Care Insurance Policy

Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified below:

All Eligible Employees

Employee Only coverage:	\$7.72
Employee + Spouse coverage:	\$15.66
Employee + Children coverage:	\$16.40
Employee + Family coverage:	\$20.76



Renewal for City of Santa Fe

February 27, 2012

**Dawn Montano
Aon Risk Solutions
6000 Uptown Blvd. NE, Suite 400
Albuquerque, NM 87110**

Dear **Dawn**:

On behalf of UnitedHealthcare Specialty Benefits, I am pleased to present renewal information for **City of Santa Fe**, for the period, **07/01/2012 – 06/30/2015**.

Your **Vision renewal** covers the cost of well vision care and corrective lenses and eyewear with affordable premiums and copays, as well as lower out-of-pocket expenses. The network includes more than 30,000 private practice and retail providers of vision services.

In addition, we offer several other insurance products – each with flexible benefit options and value-added services. Many companies appreciate the convenience of purchasing multiple insurance products from one carrier. *Please contact me for more information or to request a formal proposal for any of the products in our portfolio, including:*

- **Dental Insurance:** We offer a variety of dental plans, supported by a dental network of 100,000 dental access points nationwide and state-of-the-art online services for employers and members. We include value-added services at no additional cost, including Consumer MaxMultiplierSM, Prenatal Dental Program® and Oral Cancer Screening.
- **Life Insurance:** We offer Basic Life, Supplemental Life, Dependent Life and Accidental Death and Dismemberment (AD&D), each with flexible plan designs and special features. In addition, all life enrollees have access to Travel Assistance, Will and Trust Preparation and Beneficiary Support services at no additional cost.
- **Disability Insurance:** Our disability plans include Short Term Disability, Long Term Disability and Voluntary Disability, each with variable benefit amounts, benefit durations and elimination periods. Our disability claim management experts help claimants return to work in a timely manner.

To accept this renewal and let it serve as our agreement to continue to provide coverage(s), please confirm acceptance by notifying me within 30 days. The proposed renewal rates may automatically change on the above listed renewal date. Thank you for the opportunity to serve you and your customers. We look forward to continuing our relationship for many years to come.

Sincerely,

Carlos Guzman,
Strategic Account Executive
Specialty Benefits
UnitedHealthcare

UnitedHealthcare Life and Disability products are provided by or through Unimerica Insurance Company, United HealthCare Insurance Company or their affiliates. UnitedHealthcare Dental and Vision coverage provided by or through United HealthCare Insurance Company or its affiliates.



Vision Renewal & Rates

Customer Name: City Of Santa Fe
Client ID: G9GR
Policy Number: 712215

Situs State: NM
Renewal Effective Date: 7/1/2012

Vision Services*		Renewal V1005	
Legal Entity		UnitedHealthcare Insurance Company	
Exams/Lenses/Frames		12/12/12	
Plan Options			
Contribution		100% Employee Paid	
Exam Co-pay		\$10	
Material Co-pay		\$10	
Benefits		In-Network	Out-of-Network
Eye Examination			
Exam		100%	Up to \$40
Lenses			
Single Vision		100%	Up to \$40
Lined Bifocal		100%	Up to \$60
Lined Trifocal		100%	Up to \$80
Lenticular		100%	Up to \$80
Frames*			
Retail Frame Allowance		Up to \$130	Up to \$45
30% Discount on Frame Overage*		Incl	N/A
Elective Contact Lenses**			
Covered-in-Full Selection Contacts		4 Boxes	Up to \$105
Non-Selection Contacts		Up to \$105	Up to \$105
Necessary Contact Lenses		100%	Up to \$210
Lens Options (In Network Only)			
Lens Options Covered-in-Full		See Below	N/A
Rates			
	Enrollment	Current	Renewal
Employee	137	\$7.72	\$7.72
Employee + Spouse	106	\$15.66	\$15.66
Employee + Child(ren)	54	\$16.40	\$16.40
Employee + Family	155	\$20.76	\$20.76
Monthly Premium	452	\$6,821.00	\$6,821.00
Annual Premium		\$81,852.00	\$81,852.00
Renewal Action		0.0%	
Commission		0.0%	
Rate Guarantee / Rate End Date		36 Months	7/1/2015

- ✓ United Healthcare reserves the right to adjust the above rates should enrollment fluctuate by +/- 10%.
- ✓ Rates assume no changes in legislation or regulation that affects the benefits payable, eligibility or contract.
- ✓ Eligible Dependent children covered to age 26.
- ✓ For any frame costing more than the allowance, the member only pays the difference between the retail cost of the frame and the allowance, plus any applicable copay.
- ✓ Rates listed above are not included in quoted Medical rates (if applicable).
- ✓ Frame Benefit: All wholesale frames less than our allowance are covered in-full at private practice providers.
- ✓ Voluntary plan rates are based on 0% Employer contribution level and maintaining employee participation +/-10%.
- ✓ Lens Options: Scratch Coating.

*** Frame Benefit**

- ✓ Plan participants receive a frame allowance toward the retail cost of frames purchased at any in-network provider.
- ✓ Frames less than the allowance require no additional out of pocket for the member, other than applicable copay.
- ✓ If the member chooses a frame that exceeds their allowance, the member only pays the difference, plus any applicable copay.
- ✓ As an added value many of our providers offer a 30% discount on the balance, or frame overage, if the member exceeds their allowance.
- ✓ Frame discounts do not apply when prohibited by the manufacturer.

**** Contact Lens Benefit**

- ✓ When members visit a network provider, our contact lens benefit covers in full (after applicable copay) the fitting/and evaluation fees, many popular contact lenses (including disposables), and up to two follow-up visits.
- ✓ Members who select contact lenses outside of the covered-in-full selection will receive an allowance towards the fitting/and evaluation fees and purchase of the contact lenses (in this case the materials copay would not apply).

Other Member Benefits

- ✓ 20% discount on additional materials not covered-in-full (at participating providers).
- ✓ Discounts on lens options not covered-in-full (at participating providers).
- ✓ Access to discounts on laser vision correction.
- ✓ Ability to print an online ID card, find a provider, access plan information and more by visiting www.myuhcvision.com



Acceptance of Renewal

I accept this renewal on behalf of **City of Santa Fe**:

Authorized Signature: _____ Date: _____

Printed Name: _____ Title: _____

Please sign and submit to:

Carlos Guzman
Strategic Account Executive
Specialty Benefits
UnitedHealthcare
3110 Lake Center Drive, Santa Ana CA 92704
phone (714) 513-6427 | efax: (414) 721-0894 | email: carlos_guzman@uhc.com