

# Retiree Summary Benefits Overview

Prepared Exclusively For:

**SCS VEBA**

Group Number:

Product: **HMO**

Effective: **01/01/2011**

Through: **12/31/2011**

This is a highlight of benefits only and is not all inclusive of the Plan's benefits, services, limitations or exclusions. Please refer to the Retiree Benefits Summary Brochure/Insert and Evidence of Coverage and Disclosure Information for additional details on the plan.

BENEFITS AND COVERAGE	YOUR COSTS						Additional Notes
	In-Network Services	In-Network Copay	In-Network Coinsurance	Out-of-Network Services	Out-of-Network Copay	Out-of-Network Coinsurance	
<b>Physician Services</b>							
Primary Care Physician		\$5					per office visit
Specialist		\$5					per office visit
<b>Emergency Department Services</b>							
Includes Worldwide Coverage		\$50					cost share is waived if admitted to the hospital within 24 hours for the same condition
<b>Urgently Needed Care</b>							
In-area/in-network provider other than primary care physician		\$5					cost share is waived if admitted to the hospital within 24 hours for the same condition
Out-of-Network (includes Worldwide coverage) other than primary care physician		\$25					cost share is waived if admitted to the hospital within 24 hours for the same condition
<b>Ambulance Services</b>		\$0					
<b>Inpatient Hospital Care</b>							
Day Range 1 or Per Admit Cost Share	<b>Per Admit</b>	\$0					
Per Day/Per Admit							
Beginning day range 1							
End day range 1							
Day range 2 Cost Share							
Beginning day range 2							
End day range 2							
<b>Transplant</b>							
Professional services copay in addition to facility charges		\$0					cost share for transplant services, for Professional fees and other transplant related health services provided in a designated transplant facility.
<b>Home Healthcare Agency</b>							
Home Care Visits		\$0					per visit
<b>Outpatient Hospital Services</b>							
(includes observation, medical and surgical care)		\$0					per surgery
<b>Medical Nutrition Therapy</b>		\$0					cost share
<b>Outpatient X-ray Services</b>		\$0					cost share
<b>Clinical Laboratory Services</b>		\$0					cost share
<b>Blood and its Administration</b>		\$0					cost share
<b>Bone Mass Measurements</b>		\$0					cost share
<b>Colorectal Screening Exams</b>		\$0					cost share
<b>Annual Screening Mammograms</b>		\$0					cost share
<b>Pap Smears and Pelvic Exams</b>		\$0					cost share
<b>Annual Prostate Cancer Screening Exams</b>		\$0					cost share
<b>Cardiovascular Disease Testing</b>		\$0					cost share
<b>Physical Exams</b>							cost share
One-time "Welcome to Medicare" Exam		\$0					cost share
Annual Routine Physical Examination		\$0					cost share
<b>Immunizations</b>							
(Flu, Pneumococcal, Pneumonia,		\$0					cost share

# Retiree Summary Benefits Overview

Prepared Exclusively For:

**SCS VEBA**

Group Number:

Product: **HMO**

Effective: **01/01/2011**

Through: **12/31/2011**

This is a highlight of benefits only and is not all inclusive of the Plan's benefits, services, limitations or exclusions. Please refer to the Retiree Benefits Summary Brochure/Insert and Evidence of Coverage and Disclosure Information for additional details on the plan.

BENEFITS AND COVERAGE	YOUR COSTS						Additional Notes
	In-Network Services	In-Network Copay	In-Network Coinsurance	Out-of-Network Services	Out-of-Network Copay	Out-of-Network Coinsurance	
and Hepatitis B Vaccines)							
<b>Dental Services</b>							
Preventive (non-Medicare covered)			<b>Standard DHMO</b>				per visit
<b>Hearing Services</b>							
Routine Hearing Exam - every 12 months		\$0					cost share
Hearing Aid			<b>Standard \$500</b>				
Hearing Aid Allowance - includes Digital hearing Aids							
Benefit per ear or combined			<b>Combined 999</b>				
# of Hearing Aids			<b>every 36 months</b>				
Hearing Aid period in months							
<b>Outpatient Prescription Drugs</b>							
Part D Gap Coverage			<b>Full Coverage</b>				
Formulary Name			<b>Formulary G</b>				
Formulary Number							
Bonus Drug List							
<b>Part D Retail</b>							
Tier 1 Preferred Generic					\$7		
Tier 2 Preferred Brand					\$14		
Tier 3 Non-Preferred					\$14		
Tier 4 Specialty					\$14		
<b>Part D Mail Service</b>							
Tier 1 Preferred Generic					\$14		
Tier 2 Preferred Brand					\$28		
Tier 3 Non-Preferred					\$28		
Tier 4 Specialty					\$28		
<b>RDS Retail</b>							
Generic							
Brand							
Non-Formulary							
<b>RDS Mail Service</b>							
Generic							
Brand							
Non-Formulary							
<b>Out-of-Pocket Maximum</b>							
Annual Out-of-Pocket Maximum In-Network			<b>\$6,700</b>				
Annual Out-of-Pocket Max Out-of-Network							
<b>Annual Deductible</b>							
Annual Deductible 1 In-Network							
Annual Deductible 1 Out-of-Network							
* Inpatient Hospital copayments are charged on a per admission or daily basis. Original Medicare hospital benefit periods do not apply. For Inpatient Hospital, you are covered for an unlimited number of days as long as the hospital stay is medically necessary and authorized by UnitedHealthcare or contracting providers. When you are admitted to an Inpatient Hospital and then subsequently transferred to another Inpatient Hospital, you pay the copayment charged for the first hospital admission. You do not pay a copayment for the second hospital admission; the copayment is waived.							
SecureHorizons® Medicare Advantage plans are offered by United HealthCare Insurance Company and its affiliated companies, Medicare Advantage Organizations with a Medicare contract. Limitations, copayments and coinsurance may apply. Benefits may vary by employer group.							

<b>Group Name (All CAPS - 30 character limit including spaces)</b>	<b>SCS VEBA</b>
Corporate Group Number (30 characters)	EGSO00540
Group Number	
Product (Note: POS plans should be HMOPOS)	HMO
Plan Type	Non-Standard
Product Combination	MAPD
Plan Description	Plan 1 NS
Are the out-of-network benefits and cost share the same as in-network benefits and cost share (If no OON benefit, leave blank)	
Effective Date (MM/DD/YYYY)	01/01/2011
Expiration Date (MM/DD/YYYY)	12/31/2011
Plan year	2011
CMS H/R Contract Number (Sr Sup valid values are SRSUP, SRSEC)	H0543
Plan Benefit Package (PBP) (900 series for Sr Sup; see table of situs state PBPs)	805
Legal Entity (MA=Leave blank and will be pulled from HPMS system based on contract)(Sr Sup=UnitedHealthcare Insurance Company)	
Core System (NICE, COSMOS, PULSE)	NICE
Line of Business (SH, PHS (includes Sr Sup/Sr Sec), SH SRS, SH OXH, SH RV)	SH
Brand (MDUHC=UnitedHealthcare)	UHC
Plan Name (MA =Leave blank and will be pulled from HPMS system based on contract) Sr Sup/Sr Sec use dropdowns	
OpenAccess or Gatekeeper (MA products=Answer for HMO or POS only. Source is Product Grid on PULSE; CMS filed plans and service area tab). Sr Sup=OpenAccess	GateKeeper
Passport- MA=Response of Y or N required for all products. Sr Sup=blank	N
Leave blank	
Service Area (Sr Sup=Nationwide or Texas; MA=state name except for NPPO=Nationwide)	California
Counties in Service Area (For MA with a state name in row 23, this row is = Plan, data will come from HPMS. If Row 23 = Nationwide, row 24 is to be left blank for MA and Sr Sup.)	Plan

Description	In-Network Services	In-Network Copay	In-Network Coinsurance	Out-of-Network Services	Out-of-Network Copay	Out-of-Network Coinsurance
Annual Deductible 1 In-Network						
Annual Deductible 1 Out-of-Network						
Annual Deductible 2 In-Network						
Annual Deductible 2 Out-of-Network						
Annual Deductible Package Number (Package contains benefits for both in and out of network, but if there is a deductible, only place the package number in column E) Blank = no deductible						
Annual Out-of-Pocket Maximum In-Network (Column E)	\$6,700.00					
Annual Out-of-Pocket Maximum Out-of-Network (Column H)						
Is Annual Out-of-Pocket Maximum Combined for in and out of network? Leave blank if there is no OOP max.						
Annual Out-of-Pocket Maximum Package Number (Package contains benefits for both in and out of network, but only place package number in column E) Blank=no OOP max	P 100					
Deductible Applies To Out-of-Pocket Maximum (Column E only. Leave blank if no deductible)						
Are the services that apply toward the Out-of-Pocket Maximum the same for In-Network Services and Out-of-Network Services? (Cost share can be different) Entered only in column E if there is an OOP max and the plan has OON services. (Leave blank if there are no OOP max or the plan does not have out of network services.)						
<b>PHYSICIAN SERVICES</b>						
Primary Care Physician Office Visit (includes Non-MD office visits) cost share			\$5.00			
Specialist Office Visit cost share			\$5.00			
<b>INPATIENT SERVICES</b>						
Leave blank						
Inpatient Hospital Stay Benefit Period in days. (A "benefit period" begins the first day of admission and ends when the member hasn't received any hospital care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins and the copay cycle starts over. ) Unlimited benefit period = 999.	999					
<b>Inpatient Hospital Stay - Cost Share for Day Range 1 or Per Admit (Includes Inpatient Substance Abuse)</b>			\$0.00			
Per Day/Per Admit	Per Admit					
Beginning day range 1						
End day range 1						
Inpatient Hospital Stay - day range 2 Cost Share						
Beginning day range 2						
End day range 2						
Inpatient Hospital Stay - day range 3 Cost Share						
Beginning day range 3						
End day range 3						
Skilled Nursing Facility Care - prior hospital stay requirement waived	Y					
Skilled Nursing Facility Care - Benefit Period (In days)	100					
Skilled Nursing Facility Care day Range 1 - Cost Share			\$0.00			
Beginning day range 1	1					
End day range 1	100					
Skilled Nursing Facility Care day range 2 - Cost Share						
Beginning day range 2						
End day range 2						
Skilled Nursing Facility Care day range 3 - Cost Share						
Beginning day range 3						
End day range 3						
Leave blank						
Inpatient Mental Health in a Psychiatric Hospital Stay Benefit Period in days - default to 999 if no benefit periods	999					
<b>Inpatient Mental Health in a Psychiatric Hospital - Cost Share</b>			\$0.00			
Per Day/Per Admit	Per Admit					
Lifetime Maximum # of days (Inpatient Mental Health) Unlimited 999	190					
Beginning day range 1						
End day range 1						
Inpatient Mental Health in a Psychiatric Hospital - day range 2 Cost Share						
Beginning day range 2						
End day range 2						
Inpatient Mental Health in a Psychiatric Hospital - day range 3 Cost Share						
Beginning day range 3						
End day range 3						
<b>Transplants - Professional services copay in addition to facility charges</b>			\$0.00			
<b>OUTPATIENT SERVICES</b>						
Outpatient Surgery - Facility Component cost share			\$0.00			
Leave blank						
Outpatient Hospital Services Cost share			\$0.00			
Leave blank						
Outpatient Mental Health/Substance Abuse (Individual Visit) Cost share			\$5.00			
Outpatient Mental Health/Substance Abuse (Group Visit) Cost share			\$5.00			
Partial Hospitalization (Mental Health Day Treatment) per day - Cost Share			\$50.00			
Comprehensive Outpatient Rehabilitation Facility (CORF) cost share			\$5.00			
Occupational Therapy Cost share			\$5.00			
Physical Therapy and Speech/Language Therapy Cost share			\$5.00			
Cardiac/Pulmonary Rehabilitation Cost share			\$5.00			
Kidney Dialysis Cost share			\$5.00			
<b>Medicare-covered Specialist Visits</b>						
Chiropractic Visit (Medicare-covered) Cost share			\$5.00			
Podiatry Visit (Medicare-covered) Cost share			\$5.00			
Eye Exam, includes Glaucoma (Medicare-covered) Cost share			\$5.00			
Eyewear Allowance for Frames (Medicare-covered after cataract surgery; always a dollar value for MA) (Sr Sup=\$0 because there is no allowance but member is reimbursed for Medicare covered frames and lenses)	\$75.00					
Eyeglass Lenses or Contact Lenses (Medicare-covered after cataract surgery; always included for MA and Sr Sup)	Included					
Hearing Exam (Medicare-covered) Cost share			\$5.00			
Dental Services (Medicare-covered) Cost share			\$5.00			

Description	In-Network Services	In-Network Copay	In-Network Coinsurance	Out-of-Network Services	Out-of-Network Copay	Out-of-Network Coinsurance
Smoking Cessation Visit (Medicare-covered) Cost share		\$5.00				
Smoking Cessation # of visits	8					
<b>AMBULANCE/EMERGENCY ROOM/URGENT CARE</b>						
Ambulance Services Cost share		\$0.00				
Ambulance Copay Waived if Admitted	N					
Emergency Room (MA includes Worldwide coverage) Cost share		\$50.00				
Emergency Room Copay Waived if Admitted within 24 hours	Y					
Urgently Needed Care - Sr Sup (2010 value=PFFS) Cost share						
Urgently Needed Care (MA In-Network) Cost share		\$5.00				
Urgently Needed Care (MA Out-of-Network includes Worldwide coverage) Cost share		\$25.00				
Urgent Care Copay Waived if Admitted within 24 hours Cost share	Y					
<b>PART B DRUGS AND BLOOD</b>						
Part B Drugs - Immunosuppressives, Oral Chemotherapy, Anti-nausea, Inhalation Solutions, Hemophilia Clotting Factors Cost share		\$0.00				
Part B Drugs - Antigens		\$0.00				
Part B Drugs - Outpatient Injectable Medications - Administered in a Physician's Office		\$0.00				
Outpatient Injectable Medications - Self-Administered (Part B or D cost share)	Part B					
Outpatient Injectable Medications - Home Health (Part B or D cost share)	Part D					
Home Infusion Drugs (Part B or D cost share)	Part D					
Blood Cost share		\$0.00				
Blood 3 pint deductible waived	Y					
<b>DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES</b>						
Durable Medical Equipment Cost share		\$0.00				
Orthotics and Prosthetics Cost share		\$0.00				
Medical Supplies Cost share		\$0.00				
Diabetes Monitoring Supplies Cost share		\$0.00				
<b>HOME HEALTHCARE AGENCY</b>						
Home Health Services Cost share		\$0.00				
<b>HOSPICE</b>						
Hospice (Medicare-covered) Cost share		\$0.00				
<b>PROCEDURES</b>						
Clinical Laboratory Services Cost share		\$0.00				
Outpatient X-ray Services Cost share		\$0.00				
Diagnostic Radiology Service Cost share		\$0.00				
Therapeutic Radiology Service Cost share		\$0.00				
<b>PREVENTIVE SERVICES</b>						
Cardiovascular Screenings (Medicare-covered) Cost share		\$0.00				
Immunizations (Flu, Pneumococcal, Hepatitis B Vaccines) - (Medicare-covered+) Cost share		\$0.00				
Pap Smears and Pelvic Exams (frequency in months in Column E and cost share in F or G) OON plan needs frequency in column H and cost share in columns I or J. Frequency is equal to combined benefit in and out of network.	12	\$0.00				
Prostate Cancer Screening (frequency in months in Column E and cost share in F or G) OON plan needs frequency in column H and cost share in columns I or J. Frequency is equal to combined benefit in and out of network.	12	\$0.00				
Colorectal Cancer Screenings (frequency in months in Column E and cost share in F or G) OON plan needs frequency in column H and cost share in columns I or J. Frequency is equal to combined benefit in and out of network.	12	\$0.00				
Bone Mass Measurement (Bone Density) (frequency in months in Column E and cost share in F or G) OON plan needs frequency in column H and cost share in columns I or J. Frequency is equal to combined benefit in and out of network.	12	\$0.00				
Mammography (frequency in months in Column E and cost share in F or G) OON plan needs frequency in column H and cost share in columns I or J. Frequency is equal to combined benefit in and out of network.	12	\$0.00				
Diabetes - Self-Management Training Cost share		\$0.00				
Medical Nutrition Therapy and Counseling Cost share		\$0.00				
Physical Exam - a one-time "Welcome to Medicare" (includes an EKG) Cost share		\$0.00				
Routine Physical Exam (Non Medicare-covered) (frequency in months in Column E and cost share in G or H. Blank if not covered. OON plan needs frequency in column H and cost share in columns I or J. Frequency is equal to combined benefit in and out of network.	12	\$0.00				
<b>OUTPATIENT PRESCRIPTION DRUGS</b>						
Prescription Drug Plan Type (RDS is always custom) (Blank if no Rx)	Custom					
Part D Gap Coverage (Blank=no coverage in gap or RDS or MA only)	Full Coverage					
Initial Coverage Limit (CMS value for the plan year)	\$2,840.00					
TrOOP Threshold (CMS value for the plan year)	\$4,550.00					
<b>Catastrophic Coverage Benefit Amounts per CMS for the plan year</b>						
Copay for generics	\$2.50					
Copay for all other drugs	\$6.30					
Coinsurance	5.00%					
Formulary Name (Blank=no Rx)	Formulary G					
Formulary Number (blank for Commercial)						
<b>BONUS DRUG LIST (Changed for 2011 to header row only)</b>						
Bonus Drug List	LIST B					
Discount Drug List	NO					
Rx Deductible						
Rx Out-of-Pocket Maximum (Not Part B drugs or DME purchased at a pharmacy)						
Does the Rx deductible apply to the Rx Out-of-Pocket Maximum?	No					
<b>Part D Retail</b>						
Tier 1 Preferred Generic Cost share		\$7.00				
Tier 1 Preferred Generic Minimum (Currently not used; assign a footnote)						
Tier 1 Preferred Generic Maximum (Currently not used; assign a footnote)						
Tier 2 Preferred Brand Cost share		\$14.00				
Tier 2 Preferred Brand Minimum (Currently not used; assign a footnote)						
Tier 2 Preferred Brand Maximum (Currently not used; assign a footnote)						
Tier 3 Non-Preferred Cost share		\$14.00				
Tier 3 Non-Preferred Minimum (Currently not used; assign a footnote)						
Tier 3 Non-Preferred Maximum (Currently not used; assign a footnote)						
Tier 4 Specialty Cost share		\$14.00				
Tier 4 Specialty Minimum (Currently not used; assign a footnote)						
Tier 4 Specialty Maximum (Currently not used; assign a footnote)						
<b>Part D Mail Service</b>						
Tier 1 Preferred Generic Cost share		\$14.00				
Tier 1 Preferred Generic Minimum (Currently not used; assign a footnote)						
Tier 1 Preferred Generic Maximum (Currently not used; assign a footnote)						
Tier 2 Preferred Brand Cost share		\$28.00				
Tier 2 Preferred Generic Minimum (Currently not used; assign a footnote)						
Tier 2 Preferred Generic Maximum (Currently not used; assign a footnote)						
Tier 3 Non-Preferred Cost share		\$28.00				
Tier 3 Non-Preferred Minimum (Currently not used; assign a footnote)						
Tier 3 Non-Preferred Maximum (Currently not used; assign a footnote)						
Tier 4 Specialty Cost share		\$28.00				
Tier 4 Specialty Minimum (Currently not used; assign a footnote)						
Tier 4 Specialty Maximum (Currently not used; assign a footnote)						
<b>RDS Retail</b>						
Generic Cost share						
Brand Cost share						
Non-Formulary Cost share						
<b>RDS Mail Service</b>						
Generic Cost share						
Brand Cost share						
Non-Formulary Cost share						
Retail Day Supply (Blank if no Rx; 31,60 standard. 30,34 need Rx approval)	31					
<b>ADDITIONAL BENEFITS/PROGRAMS (Non Medicare-covered)</b>						
Dental Benefits (Non Medicare-covered Standard, Custom, Not Included)	Standard					
Dental (Non Medicare-covered) Plan Type (Enter in Column E and H)	Standard DHMO					

Description	In-Network Services	In-Network Copay	In-Network Coinsurance	Out-of-Network Services	Out-of-Network Copay	Out-of-Network Coinsurance
Routine Podiatry Benefits (Non Medicare-covered) - Standard,Custom,Not Included	Not Included					
Routine Podiatry (Non Medicare-covered) Cost share						
Routine Podiatry # of visits per year (usually 6) (Blank if not covered.) For plans with OON benefits, enter total visits in both Columns E and H.						
Hearing Exam (Non Medicare-covered) - Standard,Custom,Not Included	Standard					
Routine Hearing Exam - every 12 months Cost share		\$0.00				
Hearing Aid (Standard, Custom, Not Included)	Standard					
Hearing Aid Allowance - includes Digital Hearing Aids (\$9999.00 for unlimited allowance) For plans with OON benefits, list total hearing aid benefit in both columns E and H.	\$500.00					
Benefit per ear or combined (Blank if not covered)	Combined					
# of Hearing Aids (use 999 for unlimited devices)	999					
Hearing Aid period in months	every 36 months					
Vision Exam (Refraction) (Non Medicare-covered) - Standard, Custom, Not Included.	Standard					
Routine Eye Exam Refraction Cost share- every 12 months		\$5.00				
Eyewear/Contact Lenses Materials Copayment						
Contact Lenses Covered?	Included					
Eyeglasses and contact lenses combined allowance (Unlimited = \$999.00)						
Eyeglasses allowance (Unlimited = \$999.00)	\$130					
Contact Lenses allowance (Unlimited = \$999.00)	\$175					
Eyewear period in months	every 24 months					
Chiropractic Benefits (Non Medicare-covered) - Standard or Custom, Not included	Standard					
Chiropractic Visit (Non Medicare-covered) (Cost share)		\$5.00				
Chiropractic Visit Limit per year (unlimited = 999)	12					
<b>Ancillary Package Numbers</b>						
Dental Package Number						
Podiatry Package Number						
Hearing Rider Package Number						
Vision Package Number						
Eyewear Package Number						
Chiropractic Package Number						
Fitness Package Number						
Nurseline Package Number						
Other Ancillary Package Number (Advance To Wellness, Catalog, Transportation, etc.)						
<b>WELLNESS PROGRAMS</b>						
Fitness	SilverSneakers					
Caregiver	Included					
<b>Optum Programs</b>						
NurseLine (Treatment Decision Support & Access Support)	Included					
Wellness Advising	Included					
Disease Management - Chronic Heart Failure (CHF)	Included					
Disease Management - Coronary Artery Disease (CAD)/Diabetes	Included					
Disease Management - End Stage Renal Disease (ESRD)	Included					
HealthAllies Discount Program	Included					
Personal Health Management Program	Included					
Advanced Illness Care Management	Included					
<b>Benefits Available to Existing Groups Only</b>						
Non-Emergency Transportation Services (Medical-related appointments) (Cost share row)						
- Number of one-way trips to approved location						
- Number of at-home prescription deliveries						
Deluxe Rider	No					
Deluxe Rider Billing: (Who pays, Group or Member?)						
Personal Health Benefits	Not Included					
Caregiver - Enhanced	Not Included					
Dental (Preventive) - Custom (Cost share)						
Oral Exam Frequency						
Cleanings Frequency						
Bite-Wing X-Ray frequency						
Leave blank						
<b>Clinical Programs Senior Management Approval</b>						
Quit Power	Not Included					
Respiratory Care Management	Not Included					
Cancer Support Program	Not Included					
UnitedHealth At Home	Not Included					
<b>Endorsed Plan Benefits</b>						
Leave blank						
Leave blank						
Leave blank						
Leave blank						
Leave blank						
Leave blank						
Leave blank						
Leave blank						
<b>Custom Only</b>						
Acupuncture (Cost share)						
Acupuncture Number of Visits per year (999 unlimited)						
Respite Care - Cost Share						
Respite Care Allowance (\$999.00 for unlimited)						
Respite Care Hours						
Private Duty Nursing -Cost share						
Private Duty Nursing Allowance (\$999.00 for unlimited)						
Private Duty Nursing Hours						
Wigs after Chemotherapy Allowance						
Transgender	Not Included					
<b>Travel and Lodging</b>	Not Included					
Leave blank						
Travel and Lodging - Minimum Travel miles to Inpatient Facility						
Food and Lodging Allowance per day						
Food and Lodging Allowance per day while member is inpatient (complete only if different)						
Food and Lodging Lifetime Maximum						
Diagnostic Procedure/Test Cost share		\$0.00				
Chiro Maximum Allowance per visit						
Hearing - Maximum exam allowance per ear						
Is Annual Deductible Maximum Combined for In and Out of Network? Blank=No deductible or no OON. Entry goes in column E only.						
<b>SITE</b>	33-1					
<b>PLAN CODE (NICE PLANS)</b>	WBS					
Copy of MAPS to UAF Tool v2010.04.xls 2010-4-22-1011						
DBT Form 20100401						
<b>Footnotes</b>						
	F001;This footnote summarizes the Outpatient Self-Injectable benefit. For a complete footnote description, refer to the Footnote Reference List posted in Ovations Intranet-PULSE.					
TEXT OF FOOT NOTE 1						
TEXT OF FOOT NOTE 2						
TEXT OF FOOT NOTE 3						
TEXT OF FOOT NOTE 4						
TEXT OF FOOT NOTE 5						

**UnitedHealthcare Group Retiree  
 Southern CA Schools VEBA Expansion  
 Illustrative Rates for 1/1/2011 - 12/31/2011**

Option

1 2 3 4

<u>Product</u>	<u>Markets</u>	<u>State</u> <u>Abbr.</u>	<u>H #</u> <u>(Network</u> <u>based)</u>	<u>Renewal</u> <u>Group #'s</u>	1	2	3	4
HMO	California	CA	H0543		\$389.00	\$0.00	\$0.00	\$0.00

**UnitedHealthcare Group Retiree  
Southern CA Schools VEBA Expansion  
Membership Distribution**

Option 1  
Product HMO/POS

<u>Markets</u>	<u>State Abbr.</u>	<u>H # (Network based)</u>	
Arizona	AZ	H0303	
Arkansas	AR	H0401	
California	CA	H0543	920
Colorado	CO	H0609	
Connecticut	CT	H0752	
Florida	FL	H1080	
Atlanta, GA	GA	H1108	
Georgia	GA	H1111	
Spokane, WA	OR/WA	H1286	
Idaho	ID	H1303	
Kansas	KS	H1717	
Boston, MA	MA	H1944	
Maine	ME	H2001	
Missouri-St. Louis	MO/IL	H2654	
Missouri-Springfield	MO	H2654	
Omaha, NE	NE/IA	H2803	
New Jersey	NJ	H3107	
New York	NY	H3307	
North Carolina	NC	H3456	
Ohio	OH	H3659	
Oklahoma	OK	H3749	
Oregon	OR	H3805	
Oregon PPO	OR	H3812	
Chicago, IL	IL	H3887	
Pennsylvania	PA	H3921	
Rhode Island	RI	H4102	
Nashville, TN	TN	H4406	
Iowa	IA	H4456	
Illinois	IL	H4456	
Tennessee	TN	H4456	
Virginia	VA	H4456	
Austin, TX	TX	H4514	
Houston, TX	TX	H4514	
El Paso TX/New Mexico	TX/NM	H4522	
Texas	TX	H4590	
Utah	UT	H4604	
Grand Rapids, MI	MI	H4971	
Washington	WA	H5005	
Wisconsin	WI	H5253	
Hawaii	HI	H5424	
Kansas City, MO	MO	H5749	
Richmond, VA	VA	H7187	
Nevada	NV	H7949	
South Carolina	SC	H8748	
South Florida	FL	H9011	
Louisiana	LA	H9149	

<u>State</u>	<u>State Abbr.</u>
Alabama	AL
Alaska	AK
Arizona	AZ
Arkansas	AR
California	CA
Colorado	CO
Connecticut	CT
Delaware	DE
Florida	FL
Georgia	GA
Hawaii	HI
Idaho	ID
Illinois	IL
Indiana	IN
Iowa	IA
Kansas	KS
Kentucky	KY
Louisiana	LA
Maine	ME
Maryland	MD
Massachusetts	MA
Michigan	MI
Minnesota	MN
Mississippi	MS
Missouri	MO
Montana	MT
Nebraska	NE
Nevada	NV
New Hampshire	NH
New Jersey	NJ
New Mexico	NM
New York	NY
North Carolina	NC
North Dakota	ND
Ohio	OH
Oklahoma	OK
Oregon	OR
Pennsylvania	PA
Rhode Island	RI
South Carolina	SC
South Dakota	SD
Tennessee	TN
Texas	TX
Utah	UT
Vermont	VT
Virginia	VA
Washington	WA
Washington DC	DC
West Virginia	WV
Wisconsin	WI
Wyoming	WY

## UnitedHealthcare Group Retiree Southern CA Schools VEBA Expansion Stipulations

### HMO/POS/LPPO

- \* This is a preliminary quote effective 1/1/2011 - 12/31/2011.
- \* While we make every effort to honor the rates quoted (not withstanding the other quote stipulations below), we reserve the right to change these preliminary rates and/or the plan designs quoted based on approval of our 2011 bid filing by CMS and the actual National average Part D bid.
- \* To ensure proper claim adjudication effective 1/1/2011, it is imperative that we have final 1/1/2011 plan design decisions from employers as soon as possible. Final decisions received after 10/20/2010 could be problematic in terms of claim adjudication on 1/1/2011.
- \* These rates are quoted on a full replacement basis.
  
- \* This quote assumes that the employer pay 50% of the premium, on average.
- \* An Employer signature is required on a statement of contribution structure prior to open enrollment.
- \* We will need a signed statement from Southern CA Schools VEBA Expansion prior to 1/1/2011 which will include:
  - ~ Confirmation of employer contribution structure (per above) and
  - ~ Confirmation that the employer will administer any Low Income Subsidy (LIS) premium payments received from United HealthCare for Southern CA Schools VEBA Expansion retirees in accordance with CMS regulations (any LIS premium payments UnitedHealthCare receives from CMS for Southern CA Schools VEBA Expansion retirees will be passed through to Southern CA Schools VEBA Expansion from UnitedHealthCare).
- \* The UHC plan must be offered to all eligibles in our service areas, including any that currently have opted out of medical coverage.
- \* If members who have previously opted out are to be allowed back into the plan, then this fact must be disclosed at the time of quote.
- \* If the enrollment were to change by more than +/- 10% of what was assumed in the quote, we reserve the right to adjust the rates.
- \* Please note the following with regard to the drug coverage on these MA-PD products:
  - ~ We reserve the right to change our Part D formulary for calendar year 2011. We also reserve the right to change our pharmacy benefit manager and/or our pharmacy network for calendar year 2011.
  - ~ There is a specific, Part D drug formulary that applies to all of our MA-PD plan offerings.
  - ~ All plan designs include the standard catastrophic coverage per CMS regulations. Specifically, once a member reaches \$4,550 in True Out-of-Pocket prescription medication costs (TrOOP) in a given calendar year (2010 in this case), the member will pay the greater of a \$2.50 copay or 5% coinsurance for generic drugs, and the greater of a \$6.30 copay or 5% coinsurance for brand name drugs, regardless of whether these drugs are received at a retail pharmacy or through our mail order program.
  - ~ All 2010 MA-PD quotes assume employers will be responsible for administering Low Income Subsidy (LIS) payments to their eligible retirees.
  - ~ All Part D prescription drug coverage is considered to be creditable, therefore Creditable Coverage Notices are not required.
- \* Unless there are significant changes in regulation, a reduction in CMS reimbursement level, or a change in the methodology used to calculate CMS payments in the interim, UnitedHealthcare will hold the rate(s) and plan design(s) through 12/31/2011.
- \* Quote assumes \$0.00 commission level.
- \* 111 Pre-65 Medicare eligible disabled are included.
- \* The premium rate quoted herein assumes that premiums are due in full on a monthly basis on or before the last business day of the month prior to the month for which the premium applies .