

## HIGHLIGHTS OF MPS HEALTH PLAN DESIGN CHANGES November 21, 2011

### ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES

*This summary is intended to provide highlights of the changes to your MPS benefits effective July 1, 2012 or July 1, 2013 (upon expiration of your respective contract). It is not a complete description of covered benefits and exclusions under the Plans. This summary is subject to change upon the issuance of future regulations and other governmental guidance under the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Educational Reconciliation Act of 2010.*

HEALTH PLAN	PPO/INDEMNITY PLAN	EPO PLAN
<b>Third Party Administrator</b>	UnitedHealthcare	UnitedHealthcare
<b>Network</b>	United Healthcare Choice Plus Nationwide	United Healthcare Choice Nationwide
<b>Lifetime Maximum Per Covered Individual</b>	No Lifetime Limit	No Lifetime Limit

#### HOW THE PLANS WORK

**Deductible:** A flat-dollar amount of covered expenses that you pay per calendar year before coinsurance benefits are payable.

**Coinsurance:** After the deductible is met, the plan pays a percentage of most covered expenses and you pay a percentage; your percentage is coinsurance.

After you pay the annual (calendar year) deductible, the Plan pays a percentage (coinsurance) of eligible expenses in-network or out-of-network up to the annual coinsurance limits as listed below. Once the single or family coinsurance limit is met, the plan will pay 100% of eligible expenses for the remainder of the calendar year for covered services that are subject to coinsurance. Note: The EPO Plan is in-network only.

**Co-pay:** In addition to your annual deductible and coinsurance, co-pay is a flat dollar amount or percentage paid by you each time you use services that are subject to co-pay. Co-pay has no annual cap (maximum).

ANNUAL DEDUCTIBLE	CURRENT PPO/Indemnity		NEW PPO/Indemnity		CURRENT EPO	NEW EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
Individual	\$75	\$326	\$750	\$1,500	\$50	\$350
Family (3 Individuals)	\$225	\$500	\$2,250	\$4,500	\$150	\$1,050
<b>ANNUAL COINSURANCE</b>	<b>90%</b>	<b>70%</b>	<b>80%</b>	<b>50%</b>	<b>90%</b>	<b>80%</b>
Individual	\$200	\$1,100	\$2,500	\$3,000	\$150	\$1,000
Family (3 Individuals)	\$600	\$2,800	\$7,500	\$9,000	\$450	\$3,000
<b>Calendar Year Deductible and Coinsurance Limits</b>	Annual coinsurance limits and deductible are NOT combined between in- and out-of-network. Coinsurance does NOT include the deductible or co-pays.		Annual coinsurance limits and deductible are NOT combined between in- and out-of-network. Coinsurance does NOT include the deductible or co-pays.		Annual coinsurance limit does NOT include the deductible or co-pays.	Annual coinsurance limit does NOT include the deductible or co-pays.

COINSURANCE ITEMS Subject to Medical Necessity	CURRENT PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		NEW PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
<b>HOSPITAL SERVICES</b> Inpatient Outpatient  <b>SURGERY</b>  <b>PHYSICIAN IN-HOSPITAL SERVICES</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.
<b>ALCOHOL AND DRUG ABUSE</b> Inpatient Outpatient  <b>MENTAL HEALTH SERVICES</b> Inpatient Outpatient  (Transitional Treatment included in outpatient coverage.)	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	Inpatient - 80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.  Outpatient – 100% after \$20 co-pay.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. (Prior authorization through UHC Designee is required.)	Inpatient - 80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year. (Prior authorization through UHC Designee is required.)  Outpatient – 100% after \$20 co-pay.
<b>SPECIALIST (Office Visits)</b>  <b>ALLERGY TESTING</b>  <b>EYE CARE (Accident/Disease Only)</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	\$35 co-pay per office visit.  Testing - 80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100% after \$10 co-pay.	\$35 co-pay per office visit.  Testing - 80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.
<b>ALLERGY INJECTIONS</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	\$35 co-pay per office visit.  80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100% - injection without office visit. 100% after \$10-co-pay – injection with office visit.	\$35 co-pay per office visit.  80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.
<b>IMMUNIZATIONS AND INJECTIONS</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year – immunizations at 100% with deductible waived for children, birth to age 6.)	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – immunizations at 100% with deductible waived for children, birth to age 6.	100% after \$35 co-pay 100% of eligible expenses for remainder of calendar year – immunizations at 100% with deductible waived for children, birth to age 6.  SEE PREVENTIVE CARE	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – immunizations at 100% with deductible waived for children, birth to age 6.	100% after \$10-co-pay – immunizations at 100% with co-pay waived for children, birth to age 6.	100% after \$35-co-pay – immunizations at 100% with co-pay waived for children, birth to age 6.  SEE PREVENTIVE CARE

COINSURANCE ITEMS Subject to Medical Necessity	CURRENT PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		NEW PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
<b>PODIATRIST SERVICES</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year. Routine foot care not covered.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Routine foot care not covered.	\$35 co-pay per office visit. 80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year. Routine foot care not covered.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Routine foot care not covered.	100% after \$10 co-pay. Routine foot care not covered.	\$35 co-pay per office visit. 80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year. Routine foot care not covered.
<b>PHYSICAL / SPEECH OCCUPATIONAL THERAPY</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100% after \$20 co-pay.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100% after \$10 co-pay subject to calendar year limits of 20 visits physical therapy, 20 visits occupational therapy, and 20 visits speech therapy.	100% after \$20 co-pay subject to calendar year limits of 20 visits physical therapy, 20 visits occupational therapy, and 20 visits speech therapy.
<b>DIAGNOSTIC X-RAY AND LAB RADIATION THERAPY CHEMOTHERAPY BLOOD/BLOOD PLASMA</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.
<b>CHIROPRACTIC (Spinal Manipulation)</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 50 visits per calendar year, combined limit for in- and out-of-network.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 50 visits per calendar year, combined limit for in- and out-of-network.	100% after \$20 co-pay up to 26 visits per calendar year, combined limit for in- and out-of-network.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 26 visits per calendar year, combined limit for in- and out-of-network.	100% after \$10 co-pay.	100% after \$20 co-pay.
<b>DURABLE – MEDICAL EQUIPMENT</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year only for a single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination. Benefits are limited to \$2,500 per calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year only for a single purchase (including repair/replacement) of a type of DME once every 3 calendar years as specified and approved through UHC care coordination. Benefits are limited to \$2,500 per calendar year.
<b>ROUTINE MAMMOGRAM</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – 1 mammogram per calendar year for covered females age 40 and over.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – 1 mammogram per calendar year for covered females age 40 and over.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – 1 mammogram per calendar year for covered females age 40 and over.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – 1 mammogram per calendar year for covered females age 40 and over.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year.
			SEE PREVENTIVE CARE			SEE PREVENTIVE CARE

COINSURANCE ITEMS Subject to Medical Necessity	CURRENT PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		NEW PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
<b>MATERNITY</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year, including voluntary sterilization and voluntary abortion – dependent daughters covered.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year, including voluntary sterilization and voluntary abortion – dependent daughters covered.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year, (\$35 co-pay initial office visit) coverage includes voluntary sterilization and voluntary abortion – dependent daughters covered.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year, including voluntary sterilization and voluntary abortion – dependent daughters covered.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. (\$10 co-pay initial office visit) – coverage includes voluntary sterilization and voluntary abortion – dependent daughters covered.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. (\$35 co-pay initial office visit) – coverage includes voluntary sterilization and voluntary abortion – dependent daughters covered.
<b>CONTRACEPTIVES</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year, including injectable contraceptives that are not self-administered and inserted and implanted contraceptive devices.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year, including injectable contraceptives that are not self-administered and inserted and implanted contraceptive devices.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year, including injectable contraceptives that are not self-administered and inserted and implanted contraceptive devices.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year, including injectable contraceptives that are not self-administered and inserted and implanted contraceptive devices.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year for non-self injectable contraceptives and implanted contraceptive devices in doctor offices.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year for non-self injectable contraceptives and implanted contraceptive devices in doctor offices.
<b>INFERTILITY</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year – artificial insemination (6 cycle’s lifetime maximum). Advanced reproductive technology including in vitro fertilization to lifetime maximum of \$30,000.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – artificial insemination (6 cycle’s lifetime maximum). Advanced reproductive technology including in vitro fertilization to lifetime maximum of \$30,000.	\$35 co-pay per office visit. 80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year – artificial insemination. Advanced reproductive technology including in vitro fertilization to lifetime maximum of \$30,000.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – artificial insemination. Advanced reproductive technology including in vitro fertilization to lifetime maximum of \$30,000.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for up to lifetime maximum of \$2,000. (Any related office visit will be subject to \$10 co-pay.)	\$35 co-pay per office visit. 80% after deductible until your annual coinsurance limit is met; thereafter, 100% for up to lifetime maximum of \$2,000. (Any related office visit will be subject to \$35 co-pay.)
<b>ORGAN TRANSPLANTS</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; in conjunction with National Program for Medical Excellence.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; in conjunction with National Program for Medical Excellence.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; in conjunction with National Program for Medical Excellence.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; in conjunction with National Program for Medical Excellence.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limited to bone marrow, cornea, liver, kidney, heart, lung, heart/lung, liver/small bowel, pancreas, small bowel, kidney/pancreas, peripheral stem cell, and cornea transplants when authorized by UHC Care Coordination.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limited to bone marrow, cornea, liver, kidney, heart, lung, heart/lung, liver/small bowel, pancreas, small bowel, kidney/pancreas, peripheral stem cell, and cornea transplants when authorized by UHC Care Coordination.

COINSURANCE ITEMS Subject to Medical Necessity	CURRENT PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		NEW PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
<b>HEARING AIDS, COCHLEAR IMPLANTS Coverage for Children Under 18 Years of Age</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limit of one hearing aid per ear every three years.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limit of one hearing aid per ear every three years.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limit of one hearing aid per ear every three years.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limit of one hearing aid per ear every three years.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limit of one hearing aid per ear every three years.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Limit of one hearing aid per ear every three years.
<b>TEMPOROMANDIBULAR JOINT DISORDER</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – surgical and non-surgical diagnosis and treatment.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – surgical and non-surgical diagnosis and treatment.	\$35 co-pay per office visit.  80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – surgical and non-surgical diagnosis and treatment.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – surgical and non-surgical diagnosis and treatment.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Diagnostic and non-surgical treatments are limited to a maximum of \$1,250 per calendar year.	\$35 co-pay per office visit.  80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year. Diagnostic and non-surgical treatments are limited to a maximum of \$1,250 per calendar year.
<b>PROSTHETIC/ORTHOTIC APPLIANCES</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year for a single purchase of each type of prosthetic device once every three calendar years as specified and approved through UHC Care Coordination. Benefits are limited to \$2,500 per calendar year. Orthotics not covered.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year for a single purchase of each type of prosthetic device once every three calendar years as specified and approved through UHC Care Coordination. Benefits are limited to \$2,500 per calendar year. Orthotics not covered.
<b>WEIGHT LOSS</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	\$35 co-pay per office visit. 80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	Not covered.	Not covered.
<b>ORAL SURGERY</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – specific list of oral procedures covered.	70% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – specific list of oral procedures covered.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – specific list of oral procedures covered. Dental implants excluded.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year – specific list of oral procedures covered. Dental implants exclude..	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year limited to surgical removal of impacted wisdom teeth <u>only</u> .	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year limited to surgical removal of impacted wisdom teeth <u>only</u> .
<b>PRIVATE DUTY NURSING</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 70 eight-hour shifts per calendar year (combined limit for in- and out-of-network).	70% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 70 eight-hour shifts per calendar year (combined limit for in- and out-of-network).	80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 70 eight-hour shifts per calendar year (combined limit for in- and out-of-network).	50% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 70 eight-hour shifts per calendar year (combined limit for in- and out-of-network).	See Home Health Care.	See Home Health Care.

COINSURANCE ITEMS Subject to Medical Necessity	CURRENT PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		NEW PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
<b>SKILLED NURSING FACILITY</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 days per calendar year (combined limit for in- and out-of-network).	70% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 days per calendar year (combined limit for in- and out-of-network).	80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 days per calendar year (combined limit for in- and out-of-network).	50% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 days per calendar year (combined limit for in- and out-of-network).	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; maximum of 30 days per inpatient stay for care in conjunction with discharge from hospital and 60 days per calendar year for inpatient rehabilitation facility.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; maximum of 30 days per inpatient stay for care in conjunction with discharge from hospital and 60 days per calendar year for inpatient rehabilitation facility.
<b>SHORT-TERM REHABILITATION</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for the remainder of the calendar year (acute conditions only).	70% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year (acute conditions only).	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for the remainder of the calendar year (acute conditions only).	50% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses for remainder of calendar year (acute conditions only).	90% until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; subject to calendar limits of 20 visits pulmonary rehabilitation therapy and 36 visits cardiac rehabilitation therapy.	80% until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; subject to calendar limits of 20 visits pulmonary rehabilitation therapy and 36 visits cardiac therapy.
<b>HOME HEALTH CARE</b>	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 visits per calendar year (combined limit for in- and out-of-network).	70% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 visits per calendar year (combined limit for in- and out-of-network).	80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 visits per calendar year (combined limit for in- and out-of-network).	50% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 120 visits per calendar year (combined limit for in- and out-of-network).	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; up to maximum of 60 visits when approved in advance by UHC Care Coordination.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year; up to maximum of 60 visits when approved in advance by UHC Care Coordination.
<b>HOSPICE CARE</b>					Subject to 360 days limit for entire period you are covered under plan:	Subject to 360 days limit for entire period you are covered under plan:
Inpatient	90% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 45 days (combined limit for in- and out-of-network).	70% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 45 days (combined limit for in- and out-of-network).	80% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 45 days (combined limit for in- and out-of-network).	50% after deductible until your annual coinsurance limit is met; thereafter, 100% of eligible expenses up to 45 days (combined limit for in- and out-of-network).	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.
Outpatient	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year up to a maximum benefit of \$10,000.	70% until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year up to a maximum benefit of \$10,000.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year up to a maximum benefit of \$10,000.	50% until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year up to a maximum benefit of \$10,000.	90% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.
<b>AMBULANCE</b>	100% (deductible waived)	100% (deductible waived)	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	50% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.	100%	80% after deductible until your annual coinsurance limit is met; thereafter, 100% for remainder of calendar year.



CO-PAY ITEMS Subject to Medical Necessity	CURRENT PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		NEW PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
<b>RETAIL PHARMACY</b>	100% after the following co-pay for up to a 30-day supply at Medco participating pharmacies: <u>Tier 1:</u> Generic \$3 <u>Tier 2:</u> Preferred Brand-name 10% with a \$15 Minimum <u>Tier 3:</u> Non-preferred Brand-name 20% with a \$30 Minimum (not on preferred name-brand drug list)	100% after 30% co-pay for up to a 30-day supply.	100% after the following co-pay for up to a 30-day supply at Medco participating pharmacies: <u>Tier 1:</u> Generic \$8 <u>Tier 2:</u> Preferred Brand-name 10% with a \$25 Minimum <u>Tier 3:</u> Non-preferred Brand-name 20% with a \$50 Minimum (not on preferred name-brand drug list)	None.	100% after the following co-pay for up to a 30-day supply at Medco participating pharmacies: <u>Tier 1:</u> Generic \$3 <u>Tier 2:</u> Preferred Brand-name 10% with a \$15 Minimum <u>Tier 3:</u> Non-preferred Brand-name 20% with a \$30 Minimum (not on preferred name-brand drug list)	100% after the following co-pay for up to a 30-day supply at Medco participating pharmacies: <u>Tier 1:</u> Generic \$8 <u>Tier 2:</u> Preferred Brand-name 10% with a \$25 Minimum <u>Tier 3:</u> Non-preferred Brand-name 20% with a \$50 Minimum (not on preferred name-brand drug list)
<b>MAIL ORDER PHARMACY</b>	100% after the following co-pays for a 90-day supply at Medco mail order pharmacy: <u>Tier 1:</u> Generic \$6 <u>Tier 2:</u> Preferred Brand-name \$30 <u>Tier 3:</u> Non-preferred Brand-name \$60 (not on preferred name-brand drug list)	None.	100% after the following co-pays for a 90-day supply at Medco mail order pharmacy: <u>Tier 1:</u> Generic \$16 <u>Tier 2:</u> Preferred Brand-name \$50 <u>Tier 3:</u> Non-preferred Brand-name \$100 (not on preferred name-brand drug list)	None.	100% after the following co-pay for a 90-day supply at Medco mail order pharmacy: <u>Tier 1:</u> Generic \$6 <u>Tier 2:</u> Preferred Brand-name \$30 <u>Tier 3:</u> Non-preferred Brand-name \$60 (not on preferred name-brand drug list)	100% after the following co-pay for a 90-day supply at Medco mail order pharmacy: <u>Tier 1:</u> Generic \$16 <u>Tier 2:</u> Preferred Brand-name \$50 <u>Tier 3:</u> Non-preferred Brand-name \$100 (not on preferred name-brand drug list)
OTHER	CURRENT PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		NEW PPO/INDEMNITY PLAN – CHOICE PLUS UnitedHealthcare		CURRENT EPO – CHOICE UnitedHealthcare	NEW EPO – CHOICE UnitedHealthcare
NATIONAL VISION	NVA In-Network	Out-of-Network	NVA In-Network	Out-of-Network	NVA In-Network Only	NVA In-Network Only
<b>National Vision Administrators Routine Vision Coverage</b>	Annual exam, frames, lenses or contact lenses per schedule for actives ONLY.	None.	Annual exam, frames, lenses or contact lenses per schedule for actives ONLY.	None.	Annual exam, frames, lenses or contact lenses per schedule for actives ONLY.	Annual exam, frames, lenses or contact lenses per schedule for actives ONLY.

This publication provides information in general terms only as of the publication date indicated and is not intended to be a complete description of coverage. This publication is subject to the terms and conditions of the master contract of each plan, MPS Board policies, and federal or state statute.

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Publication Date: November 21, 2011