

**UnitedHealthcare Group Retiree  
 Medicare Advantage - National PPO  
 Group name: State of Kansas  
 Preliminary Rates for 1/1/2013 - 12/31/2013**



Rates are Per Member Per Month (PMPM)

		Option 1	Option 2	Option 3	Option 4
<u>Quoted Service Area</u>	<u>Membership Quoted</u>	Plan Designed to match Coventry Plan	Plan Designed to match Humana Plan	UHC Alternate Plan 1 with PDP to match Coventry Plan	UHC Alternate Plan 2 with PDP to match Coventry Plan
National	677	\$209.26	\$166.39	\$130.69	\$155.05

**Stipulations National PPO**

- This is a preliminary quote effective 1/1/2013 - 12/31/2013. The situs state is Kansas.
- To ensure proper claim adjudication effective 1/1/2013, it is imperative that we have final 1/1/2013 plan design decisions from employers as soon as possible. Final decisions received after 10/20/2012 could be problematic in terms of claim adjudication on 1/1/2013.
- These rates are quoted assuming our offering is alongside of another offering/another carrier.
- This quote assumes that the employer pay 0% of the premium, on average.
- An Employer signature is required on a statement of contribution structure prior to open enrollment.
- The UHC plan must be offered to all eligibles in our service areas.
- Quote assumes \$0.00 PMPM commission level.
- 0 Pre-65 Medicare eligible disabled are included.
- Our proposal offers a second year rate cap for 1/1/14 -12/31/14. The rate cap (increase) would be \$40.00 pmpm plus the insurers fee (annual fee assessed to and paid by United under Section 9010 of the Patient Protection and Affordable Care Act ("PPACA").)
- Our proposal offers a third year rate cap for 1/1/15 -12/31/15. The rate cap (increase) would be \$50.00 pmpm plus the insurers fee (annual fee assessed to and paid by United under Section 9010 of the Patient Protection and Affordable Care Act ("PPACA").)

**Prepared Exclusively For: STATE OF KANSAS**

**Product: National PPO Custom**

**Effective Date: 1/1/2013 Through 12/21/3013**

This is a highlight of benefits only and is Not all inclusive of the Plan's benefits, services, limitations or exclusions.

BENEFITS AND COVERAGE OPTION 1 - Plan Designed to match Coventry Plan	In-Network Services	Out-of-Network Services
<b>Annual Deductible</b>		
Annual Deductible In-Network		
Annual Deductible Out-of-Network		
Annual Deductible Combined for In and Out-of-Network		
<b>Out-of-Pocket Maximum</b>		
Annual Out-of-Pocket Maximum In-Network	\$1,000	
Annual Out-of-Pocket Max Out-of-Network		\$1,000
Annual Out-of-Pocket Max Combined for In and Out-of-Network	Y	
<b>Physician Services</b>		
Primary Care Physician	\$10	\$10
Specialist	\$25	\$25
<b>Emergency Department Services</b>		
Includes Worldwide Coverage	\$50	\$50
<b>Urgently Needed Care</b>		
Urgently Needed Care (Contracted Providers) Cost Share	\$30	\$30
Urgently Needed Care (with Non-Contracted Providers) Cost Share	\$30	\$30
<b>Ambulance Services</b>		
	\$100	\$100
<b>Inpatient Hospital Care</b>		
Per Day or Per Admit	Per Day	Per Day
Copayment per Day - Day 1 through 5	\$150	\$150
Copayment per Day - Day 6 through 999	\$0	\$0
<b>Skilled Nursing Facility Care</b>		
Copayment per Day - Day 1 through 7	\$0	\$0
Copayment per Day - Day 8 through 100	\$50	\$50
<b>Inpatient Mental Health Care</b>		
Per Day or Per Admit Cost Share	Per Day	Per Day
Copayment per Day - Day 1 through 5	\$150	\$150
Copayment per Day - Day 6 through 190	\$0	\$0
<b>Transplant</b>		
Transplants - Cost Share (Related to Travel and Lodging)	\$0	\$0
<b>Home Healthcare Agency</b>		
Home Care Visits	\$0	\$0
<b>Outpatient Services (including observation, medical and surgical care)</b>		
Outpatient Hospital Services	\$150	\$150
Physical/Speech/Occupational Therapy	\$0	\$0
Outpatient X-ray Services	\$0	\$0
Clinical Laboratory Services	\$0	\$0
Chiropractic Visit (Medicare-covered)	\$20	\$20
Podiatry Visit (Medicare-covered)	\$15	\$15
Blood first 3 pints	\$0	\$0
Bone Mass Measurements	\$0	\$0
Colorectal Screening Exams	\$0	\$0
Annual Screening Mammograms	\$0	\$0
Pap Smears and Pelvic Exams	\$0	\$0
Annual Prostate Cancer Screening Exams	\$0	\$0
Cardiovascular Screenings (Medicare-Covered)	\$0	\$0
<b>Physical Exams</b>		
Annual Wellness Exam (Physical Exam) and One-time Welcome-to-Medicare Exam. (Medicare-covered)	\$0	\$0
<b>Immunizations</b>		
(Flu, Pneumococcal, Pneumonia, and Hepatitis B Vaccines)	\$0	\$0
<b>Durable Medical Equipment</b>		
Durable Medical Equipment	20%	20%
Medical Supplies, Including Diabetic	\$0	\$0
<b>Vision Services</b>		
Eye Exam (Medicare-covered)	\$0	\$0
Routine Eye Exam refraction every 12 months	\$25	\$25
Routine Eyeglasses Allowance	\$70	\$70
Routine Contact Lenses Allowance	\$105	\$105
Routine Eyeware Period in Months	every 24 months	every 24 months
<b>Hearing Services</b>		
Routine Hearing Exam - every 12 months	\$0	\$0
Hearing Aid Allowance - includes Digital hearing aids	\$500	\$500
Benefit per ear or combined	Combined	Combined
# of Hearing Aids	999	999
Hearing Aid period in years	36	36

**Product: National PPO Custom**

<b>Part B Drugs</b>		
Part B drugs - Immunosuppressives, oral chemotherapy, anti-nausea, inhalation solutions, outpatient injectables	<b>20%</b>	<b>20%</b>
<b>Outpatient Prescription Drugs</b>		
Part D Gap Coverage	<b>Tier 1 Only</b>	
<b>Part D Retail</b>		
Tier 1 Drugs	<b>\$5</b>	
Tier 2 Drugs	<b>\$30</b>	
Tier 3 Drugs	<b>\$60</b>	
Tier 4 Drugs	<b>33%</b>	
<b>Part D Mail Service</b>		
Tier 1 Drugs	<b>\$10</b>	
Tier 2 Drugs	<b>\$60</b>	
Tier 3 Drugs	<b>\$120</b>	
Tier 4 Drugs	<b>33%</b>	
<b>Wellness Programs</b>		
Fitness	<b>SilverSneakers</b>	<b>Not Included</b>
Caregiver	<b>Standard</b>	<b>Not Included</b>
NurseLine	<b>Included</b>	<b>Not Included</b>
Treatment Decision Support	<b>Included</b>	<b>Not Included</b>
Access Support	<b>Included</b>	<b>Not Included</b>
Disease Management - Chronic Heart Failure (CHF)	<b>Included</b>	<b>Not Included</b>
Disease Management - Coronary Artery Disease (CAD)/Diabetes	<b>Included</b>	<b>Not Included</b>
Disease Management - End Stage Renal Disease (ESRD)	<b>Included</b>	<b>Not Included</b>
Personal Health Management Program	<b>Included</b>	<b>Not Included</b>
Advanced Illness Care Management	<b>Included</b>	<b>Not Included</b>
<p>* 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.</p>		
<p>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.</p>		

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BENEFITS AND COVERAGE OPTION 2 - Plan Designed to match Humana Plan	In-Network Services	Out-of-Network Services
<b>Annual Deductible</b>		
Annual Deductible In-Network	\$100	
Annual Deductible Out-of-Network		\$100
Annual Deductible Combined for In and Out-of-Network	Y	
<b>Out-of-Pocket Maximum</b>		
Annual Out-of-Pocket Maximum In-Network	\$3,000	
Annual Out-of-Pocket Max Out-of-Network		\$3,000
Annual Out-of-Pocket Max Combined for In and Out-of-Network	Y	
<b>Physician Services</b>		
Primary Care Physician	\$10	\$10
Specialist	\$35	\$35
<b>Emergency Department Services</b>		
Includes Worldwide Coverage	\$65	\$65
<b>Urgently Needed Care</b>		
Urgently Needed Care (Contracted Providers) Cost Share	\$35	\$35
Urgently Needed Care (with Non-Contracted Providers) Cost Share	\$35	\$35
<b>Ambulance Services</b>	\$100	\$100
<b>Inpatient Hospital Care</b>		
Per Day or Per Admit	Per Day	Per Day
Copayment per Day - Day 1 through 5	\$165	\$165
Copayment per Day - Day 6 through 999	\$0	\$0
<b>Skilled Nursing Facility Care</b>		
Copayment per Day - Day 1 through 10	\$0	\$0
Copayment per Day - Day 11 through 100	\$100	\$100
<b>Inpatient Mental Health Care</b>		
Per Day or Per Admit Cost Share	Per Day	Per Day
Copayment per Day - Day 1 through 5	\$165	\$165
Copayment per Day - Day 6 through 190	\$0	\$0
<b>Transplant</b>		
Transplants - Cost Share (Related to Travel and Lodging)	\$0	\$0
<b>Home Healthcare Agency</b>		
Home Care Visits	\$0	\$0
<b>Outpatient Services (including observation, medical and surgical care)</b>		
Outpatient Hospital Services	\$100	\$100
Physical/Speech/Occupational Therapy	\$35	\$35
Outpatient X-ray Services	\$0	\$0
Clinical Laboratory Services	\$0	\$0
Chiropractic Visit (Medicare-covered)	\$20	\$20
Podiatry Visit (Medicare-covered)	\$35	\$35
Blood first 3 pints	\$0	\$0
Bone Mass Measurements	\$0	\$0
Colorectal Screening Exams	\$0	\$0
Annual Screening Mammograms	\$0	\$0
Pap Smears and Pelvic Exams	\$0	\$0
Annual Prostate Cancer Screening Exams	\$0	\$0
Cardiovascular Screenings (Medicare-Covered)	\$0	\$0
<b>Physical Exams</b>		
Annual Wellness Exam (Physical Exam) and One-time Welcome-to-Medicare Exam. (Medicare-covered)	\$0	\$0
<b>Immunizations</b>		
(Flu, Pneumococcal, Pneumonia, and Hepatitis B Vaccines)	\$0	\$0
<b>Durable Medical Equipment</b>		
Durable Medical Equipment	20%	20%
Medical Supplies, Including Diabetic	\$0	\$0
<b>Vision Services</b>		
Eye Exam (Medicare-covered)	\$35	\$35
Routine Eye Exam refraction every 12 months	\$35	\$35
Routine Eyeglasses Allowance	\$70	\$70
Routine Contact Lenses Allowance	\$105	\$105
Routine Eyeware Period in Months	every 24 months	every 24 months
<b>Hearing Services</b>		
Routine Hearing Exam - every 12 months	\$0	\$0
Hearing Aid Allowance - includes Digital hearing aids	\$500	\$500
Benefit per ear or combined	Combined	Combined
# of Hearing Aids	999	999
Hearing Aid period in years	36	36

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<b>Part B Drugs</b>		
Part B drugs - Immunosuppressives, oral chemotherapy, anti-nausea, inhalation solutions, outpatient injectables	<b>20%</b>	<b>20%</b>
<b>Outpatient Prescription Drugs</b>		
Part D Gap Coverage	<b>Tier 1 Only</b>	
<b>Part D Retail</b>		
Tier 1 Drugs	<b>\$5</b>	
Tier 2 Drugs	<b>\$30</b>	
Tier 3 Drugs	<b>\$60</b>	
Tier 4 Drugs	<b>33%</b>	
<b>Part D Mail Service</b>		
Tier 1 Drugs	<b>\$10</b>	
Tier 2 Drugs	<b>\$60</b>	
Tier 3 Drugs	<b>\$120</b>	
Tier 4 Drugs	<b>33%</b>	
<b>Wellness Programs</b>		
Fitness	<b>SilverSneakers</b>	<b>Not Included</b>
Caregiver	<b>Standard</b>	<b>Not Included</b>
NurseLine	<b>Included</b>	<b>Not Included</b>
Treatment Decision Support	<b>Included</b>	<b>Not Included</b>
Access Support	<b>Included</b>	<b>Not Included</b>
Disease Management - Chronic Heart Failure (CHF)	<b>Included</b>	<b>Not Included</b>
Disease Management - Coronary Artery Disease (CAD)/Diabetes	<b>Included</b>	<b>Not Included</b>
Disease Management - End Stage Renal Disease (ESRD)	<b>Included</b>	<b>Not Included</b>
Personal Health Management Program	<b>Included</b>	<b>Not Included</b>
Advanced Illness Care Management	<b>Included</b>	<b>Not Included</b>
<p>* 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.</p>		
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<b>BENEFITS AND COVERAGE OPTION 3 - UHC Alternative Plan 1 with PDP to match Coventry Plan</b>					<b>In-Network Services</b>	<b>Out-of-Network Services</b>	
<b>Annual Deductible</b>							
Annual Deductible In-Network					\$250		
Annual Deductible Out-of-Network							
Annual Deductible Combined for In and Out-of-Network							
<b>Out-of-Pocket Maximum</b>							
Annual Out-of-Pocket Maximum In-Network					\$6,700		
Annual Out-of-Pocket Max Out-of-Network						\$6,700	
Annual Out-of-Pocket Max Combined for In and Out-of-Network					Y		
<b>Physician Services</b>							
Primary Care Physician					\$20	\$20	
Specialist					\$30	\$30	
<b>Emergency Department Services</b>							
Includes Worldwide Coverage					\$65	\$65	
<b>Urgently Needed Care</b>							
Urgently Needed Care (Contracted Providers) Cost Share					\$35	\$35	
Urgently Needed Care (with Non-Contracted Providers) Cost Share					\$35	\$35	
<b>Ambulance Services</b>					20%	20%	
<b>Inpatient Hospital Care</b>							
Per Day or Per Admit					<b>Per Day</b>	<b>Per Day</b>	
Copayment per Day -		Day	1	through	7	\$230	\$230
Copayment per Day -		Day	8	through	999	\$0	\$0
<b>Skilled Nursing Facility Care</b>							
Copayment per Day -		Day	1	through	20	\$50	\$50
Copayment per Day -		Day	21	through	100	\$146	\$146
<b>Inpatient Mental Health Care</b>							
Per Day or Per Admit Cost Share					<b>Per Day</b>	<b>Per Day</b>	
Copayment per Day -		Day	1	through	7	\$230	\$230
Copayment per Day -		Day	8	through	190	\$0	\$0
<b>Transplant</b>							
Transplants - Cost Share (Related to Travel and Lodging)					\$0	\$0	
<b>Home Healthcare Agency</b>							
Home Care Visits					\$0	\$0	
<b>Outpatient Services (including observation, medical and surgical care)</b>							
Outpatient Hospital Services					20%	20%	
Physical/Speech/Occupational Therapy					20%	20%	
Outpatient X-ray Services					20%	20%	
Clinical Laboratory Services					20%	20%	
Chiropractic Visit (Medicare-covered)					\$20	\$20	
Podiatry Visit (Medicare-covered)					\$30	\$30	
Blood first 3 pints					\$0	\$0	
Bone Mass Measurements					\$0	\$0	
Colorectal Screening Exams					\$0	\$0	
Annual Screening Mammograms					\$0	\$0	
Pap Smears and Pelvic Exams					\$0	\$0	
Annual Prostate Cancer Screening Exams					\$0	\$0	
Cardiovascular Screenings (Medicare-Covered)					\$0	\$0	
<b>Physical Exams</b>							
Annual Wellness Exam (Physical Exam) and One-time Welcome-to-Medicare Exam.					\$0	\$0	
<b>Immunizations</b>							
(Flu, Pneumococcal, Pneumonia, and Hepatitis B Vaccines)					\$0	\$0	
<b>Durable Medical Equipment</b>							
Durable Medical Equipment					20%	20%	
Medical Supplies, Including Diabetic					20%	20%	
<b>Vision Services</b>							
Eye Exam (Medicare-covered)					\$30	\$30	
Routine Eye Exam refraction every 12 months					\$30	\$30	
Routine Eyeglasses Allowance					\$70	\$70	
Routine Contact Lenses Allowance					\$105	\$105	
Routine Eyeware Period in Months					every 24 months	every 24 months	
<b>Hearing Services</b>							
Routine Hearing Exam - every 12 months					\$0	\$0	
Hearing Aid Allowance - includes Digital hearing aids					\$500	\$500	
Benefit per ear or combined					Combined	Combined	
# of Hearing Aids					999	999	
Hearing Aid period in years					36	36	

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<b>Part B Drugs</b>		
Part B drugs - Immunosuppressives, oral chemotherapy, anti-nausea, inhalation solutions, outpatient injectables	<b>20%</b>	<b>20%</b>
<b>Outpatient Prescription Drugs</b>		
Part D Gap Coverage	<b>Tier 1 Only</b>	
<b>Part D Retail</b>		
Tier 1 Drugs	<b>\$5</b>	
Tier 2 Drugs	<b>\$30</b>	
Tier 3 Drugs	<b>\$60</b>	
Tier 4 Drugs	<b>33%</b>	
<b>Part D Mail Service</b>		
Tier 1 Drugs	<b>\$10</b>	
Tier 2 Drugs	<b>\$60</b>	
Tier 3 Drugs	<b>\$120</b>	
Tier 4 Drugs	<b>33%</b>	
<b>Wellness Programs</b>		
Fitness	<b>SilverSneakers</b>	<b>Not Included</b>
Caregiver	<b>Standard</b>	<b>Not Included</b>
NurseLine	<b>Included</b>	<b>Not Included</b>
Treatment Decision Support	<b>Included</b>	<b>Not Included</b>
Access Support	<b>Included</b>	<b>Not Included</b>
Disease Management - Chronic Heart Failure (CHF)	<b>Included</b>	<b>Not Included</b>
Disease Management - Coronary Artery Disease (CAD)/Diabetes	<b>Included</b>	<b>Not Included</b>
Disease Management - End Stage Renal Disease (ESRD)	<b>Included</b>	<b>Not Included</b>
Personal Health Management Program	<b>Included</b>	<b>Not Included</b>
Advanced Illness Care Management	<b>Included</b>	<b>Not Included</b>
<p>* 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.</p>		
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<b>BENEFITS AND COVERAGE OPTION 4 - UHC Alternative Plan 2 and PDP to match Coventry Plan</b>					<b>In-Network Services</b>	<b>Out-of-Network Services</b>	
<b>Annual Deductible</b>							
Annual Deductible In-Network					\$250		
Annual Deductible Out-of-Network							
Annual Deductible Combined for In and Out-of-Network							
<b>Out-of-Pocket Maximum</b>							
Annual Out-of-Pocket Maximum In-Network					\$3,000		
Annual Out-of-Pocket Max Out-of-Network						\$3,000	
Annual Out-of-Pocket Max Combined for In and Out-of-Network					Y		
<b>Physician Services</b>							
Primary Care Physician					\$20	\$20	
Specialist					\$30	\$30	
<b>Emergency Department Services</b>							
Includes Worldwide Coverage					\$65	\$65	
<b>Urgently Needed Care</b>							
Urgently Needed Care (Contracted Providers) Cost Share					\$35	\$35	
Urgently Needed Care (with Non-Contracted Providers) Cost Share					\$35	\$35	
<b>Ambulance Services</b>					20%	20%	
<b>Inpatient Hospital Care</b>							
Per Day or Per Admit					<b>Per Day</b>	<b>Per Day</b>	
Copayment per Day -		Day	1	through	7	\$230	\$230
Copayment per Day -		Day	8	through	999	\$0	\$0
<b>Skilled Nursing Facility Care</b>							
Copayment per Day -		Day	1	through	20	\$50	\$50
Copayment per Day -		Day	21	through	100	\$146	\$146
<b>Inpatient Mental Health Care</b>							
Per Day or Per Admit Cost Share					<b>Per Day</b>	<b>Per Day</b>	
Copayment per Day -		Day	1	through	7	\$230	\$230
Copayment per Day -		Day	8	through	190	\$0	\$0
<b>Transplant</b>							
Transplants - Cost Share (Related to Travel and Lodging Only)					\$0	\$0	
<b>Home Healthcare Agency</b>							
Home Care Visits					\$0	\$0	
<b>Outpatient Services (including observation, medical and surgical care)</b>							
Outpatient Hospital Services					20%	20%	
Physical/Speech/Occupational Therapy					20%	20%	
Outpatient X-ray Services					20%	20%	
Clinical Laboratory Services					20%	20%	
Chiropractic Visit (Medicare-covered)					\$20	\$20	
Podiatry Visit (Medicare-covered)					\$30	\$30	
Blood first 3 pints					\$0	\$0	
Bone Mass Measurements					\$0	\$0	
Colorectal Screening Exams					\$0	\$0	
Annual Screening Mammograms					\$0	\$0	
Pap Smears and Pelvic Exams					\$0	\$0	
Annual Prostate Cancer Screening Exams					\$0	\$0	
Cardiovascular Screenings (Medicare-Covered)					\$0	\$0	
<b>Physical Exams</b>							
Annual Wellness Exam (Physical Exam) and One-time Welcome-to-Medicare Exam.					\$0	\$0	
<b>Immunizations</b>							
(Flu, Pneumococcal, Pneumonia, and Hepatitis B Vaccines)					\$0	\$0	
<b>Durable Medical Equipment</b>							
Durable Medical Equipment					20%	20%	
Medical Supplies, Including Diabetic					20%	20%	
<b>Vision Services</b>							
Eye Exam (Medicare-covered)					\$30	\$30	
Routine Eye Exam refraction every 12 months					\$30	\$30	
Routine Eyeglasses Allowance					\$70	\$70	
Routine Contact Lenses Allowance					\$105	\$105	
Routine Eyeware Period in Months					every 24 months	every 24 months	
<b>Hearing Services</b>							
Routine Hearing Exam - every 12 months					\$0	\$0	
Hearing Aid Allowance - includes Digital hearing aids					\$500	\$500	
Benefit per ear or combined					Combined	Combined	
# of Hearing Aids					999	999	
Hearing Aid period in years					36	36	

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<b>Part B Drugs</b>		
Part B drugs - Immunosuppressives, oral chemotherapy, anti-nausea, inhalation solutions, outpatient injectables	<b>20%</b>	<b>20%</b>
<b>Outpatient Prescription Drugs</b>		
Part D Gap Coverage	<b>Tier 1 Only</b>	
<b>Part D Retail</b>		
Tier 1 Drugs	<b>\$5</b>	
Tier 2 Drugs	<b>\$30</b>	
Tier 3 Drugs	<b>\$60</b>	
Tier 4 Drugs	<b>33%</b>	
<b>Part D Mail Service</b>		
Tier 1 Drugs	<b>\$10</b>	
Tier 2 Drugs	<b>\$60</b>	
Tier 3 Drugs	<b>\$120</b>	
Tier 4 Drugs	<b>33%</b>	
<b>Wellness Programs</b>		
Fitness	<b>SilverSneakers</b>	<b>Not Included</b>
Caregiver	<b>Standard</b>	<b>Not Included</b>
NurseLine	<b>Included</b>	<b>Not Included</b>
Treatment Decision Support	<b>Included</b>	<b>Not Included</b>
Access Support	<b>Included</b>	<b>Not Included</b>
Disease Management - Chronic Heart Failure (CHF)	<b>Included</b>	<b>Not Included</b>
Disease Management - Coronary Artery Disease (CAD)/Diabetes	<b>Included</b>	<b>Not Included</b>
Disease Management - End Stage Renal Disease (ESRD)	<b>Included</b>	<b>Not Included</b>
Personal Health Management Program	<b>Included</b>	<b>Not Included</b>
Advanced Illness Care Management	<b>Included</b>	<b>Not Included</b>
<p>* 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.</p>		
<p>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.</p>		