NOTE: There is a three-minute time limit on all comments from the public, regardless of the subject matter. A request form is available from the Deputy Town Clerk; please fill it in and return it to her prior to the start of the meeting if you would like to speak during public comment. When you speak, you must come to the podium in the front and clearly state your name and address for the record. Please turn off or mute your cell phone or pager at the start of the meeting. Thank you.

TOWN OF BAY HARBOR ISLANDS

SPECIAL COUNCIL MEETING AGENDA

October 26, 2016

CALL TO ORDER: 9:15 a.m.

PLEDGE OF ALLEGIANCE:

ROLL CALL:

1. **Discussion** and **possible action** requested by Council Member Salver and Council Member Fuller regarding giving members of the Town Council the option to join the Town's health insurance plan. The individual Council Members that would take advantage of this would be responsible for paying the full premium.

ADJOURNMENT: Approximately 9:45 a.m.

Pursuant to Florida Statutes 286.0105, the Town hereby advises the public that should any person decide to appeal any decision of the Town Council with respect to any matter to be considered at this meeting or hearing, he or she will need a record of the proceedings, and that, for such purpose he or she may need to ensure that a verbatim record of the proceedings is made, which record includes the testimony and evidence upon which the appeal is to be based.

AGENDA ITEM REPORT
October 26, 2016

ITEM NUMBER: 1.

ITEM: Discussion and **possible action** requested by Council Member Salver and Council Member Fuller regarding giving members of the Town Council the option to join the Town's health insurance plan. The individual Council Members that would take advantage of this would be responsible for paying the full premium.

DESCRIPTION:
The request is based on Council Members paying the entire premium with no cost to the Town. Should this request be approved, those wishing to join the plan will need to do so immediately after the meeting.

Enclosed is a survey of municipalities in Miami-Dade County that shows that 19 cities/towns give elected officials the ability to participate in their health insurance plans. Also attached is information on the Town's health insurance plan.

RECOMMENDED ACTION:

FINANCIAL ANALYSIS:
No cost to the Town.

BUDGET IMPACT:

Submitted By: Marlene Siegel, Town Clerk

ATTACHMENTS

1.	Survey and Plan Description	health insurance plan and survey.pdf

Health Insurance Survey for Commissioners/Council Members

City/Town/Village	Are the elected officials eligible to participate in the City/Town's Health Insurance Plan
Bal Harbour Village	Yes
City of Aventura	No
City of Coral Springs	Yes
City of Coconut Creek	Yes
City of Cooper City	Yes
City of Doral	Yes
City of Florida City	Yes (only the Mayor)
City of Hialeah Gardens	Yes
City of Homestead	Yes
City of North Bay Village	Yes
City of North Lauderdale	Yes
City of North Miami	Yes
City of North Miami Beach	Yes
City of Opa Locka	Yes
City of Pembroke Pines	Yes
City of Sunny Isles Beach	Yes
City of Sweetwater	Yes
City of West Miami	Yes
Town of Bay Harbor Islands	
Town of Golden Beach	Yes
Town of Miami Lakes	Yes
Town of Surfside	No
Village of Key Biscayne	No
Village of Miami Shores	No
Village of Pinecrest	No
TOTALS	Yes = 19 municipalities No = 5 municipalities

(VM/Survey/Health Insurance for Commissioners - Council Members
(Survey completed by Vicky Motola, Town of Bay Harbor Islands)
(10/17/2016)

Town of Bay Harbor Islands
October 1, 2016 New Medical Plan

PLAN NAME▶	NHP 4-Tier Rates F0SU NHP POS with AL
OVERVIEW	**IN-NETWORK ONLY**
Referral Required?	No, but must pick a PCP
Calendar Year Deductible (CYD)	$500 individual / $1,000 family
Individual or Family Deductible	Individual
Coinsurance	0%
Out of Pocket Maximum	$1,500 individual / $3,000 family
Lifetime Maximum Benefit	Unlimited
Out of Network Benefits -- Deductible, OOP Max, Coinsurance	$1,000 individual / $2,000 family; $6,250 individual / $12,500 family; 30%
	OOP max includes deductible, coinsurance & Rx
PHYSICIAN SERVICES	**MEMBER PAYS**
Deductible Applies?	No
Primary Care Physician	$25
Specialist Physician	$25
Urgent Care Center	$50
Preventative Care, On Schedule	$0
HOSPITAL SERVICES	**MEMBER PAYS**
Deductible Applies?	Yes
Inpatient Admission	0%
Outpatient (OP) Surgery	0%
OP Complex Imaging (MRI,PET,CT)	0%
Emergency Room Visits	$100*
	* Deductible waived
NON-HOSPITAL SERVICES	**MEMBER PAYS**
Deductible Applies?	Yes
Outpatient Surgery (ASC, ODC)	0%
OP Complex Imaging (MRI,PET,CT)	0%
Lab Work	0%*
X-Ray (Chest, etc.)	0%*
	* Deductible waived
PRESCRIPTIONS	**MEMBER PAYS**
Deductible Applies?	No
Tier 1/Tier 2/Tier 3/Tier 4	$20/$40/$60
Specialty	$20/$125/$250 (30% Growth Hormone)
Mail Order (# Days)*	2 X copay for 90-day supply
*Specialty Rx not covered by Mail Order	**Some Generics Require Mail Order w/ Opt Out**
Estimated Enrollment	**10/1/2016**
Employee Only	$537.55
Employee + Spouse	$1,150.36
Employee + Child(ren)	$1,096.60
Employee + Family	$1,644.90

Benefits displayed are a brief overview of benefits and do not reflect exact benefits; refer to carrier plan summary/SBC/contract for a more detailed & accurate description of benefits.
Rates are an estimate and are subject to final carrier underwriting. A change of one employee's or dependent's enrollment can change rates.

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 **www.welcometouhc.com** or by calling **1-800-782-3740**.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	Participating: **$500** Indiv. / **$1,000** Family Non-Participating: **$1,000** Indiv. / **$2,000** Family Per calendar year. Does not apply to copays, prescription drugs, and services listed below as "No Charge".	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, there are no other deductibles.	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?	Yes, Participating: **$1,500** Indiv / **$3,000** Family Non-Participating: **$6,250** Indiv / **$12,500** 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**?	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-certification 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 **participating providers**, see **www.welcometouhc.com** or call **1-800-782-3740.**	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 **1-800-782-3740** or visit us at **www.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 **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

- **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 an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	30% co-ins, after ded	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply. Only applies to your designated PCP.
	Specialist visit	$25 copay per visit	30% 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	$25 copay per visit	30% co-ins, after ded	Cost Share applies for only Manipulative (Chiropractic) Services and is limited to 20 visits per contract period. PCP referral is not required.
	Preventive care/screening/immunization	No Charge	30% co-ins, after ded	Includes preventive health services specified in the health care reform law. Hearing exams covered for children through age 21 and as participating only.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% co-ins, after ded	Pre-certification required for certain services non-participating or benefit reduces by 20% of allowed.
	Imaging (CT/PET scans, MRIs)	0% co-ins, after ded	30% co-ins, after ded	Pre-certification required for certain services non-participating or benefit reduces by 20% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.welcometouhc.com	Tier 1 - Your Lowest-Cost Option	Retail: $20 copay Mail-Order: $40 copay Specialty Drugs: $20 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30 day supply. Mail-Order: Up to a 90 day supply. Non-Network Pharmacy Drugs are Not Covered. 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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered. Tier 1 contraceptives are covered at No Charge. Growth Hormone Therapy : 30% co-ins
	Tier 2 - Your Midrange Cost Option	Retail: $40 copay Mail-Order: $80 copay Specialty Drugs: $125 copay	Not Covered	
	Tier 3 - Your Highest-Cost Option	Retail: $60 copay Mail-Order: $120 copay Specialty Drugs: $250 copay	Not Covered	
	Tier 4 (if applicable) - Additional High-Cost Options	Not Applicable	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-ins, after ded	30% co-ins, after ded	Pre-certification required for certain services non-participating or benefit reduces by 20% of allowed.
	Physician/surgeon fees	0% co-ins, after ded	30% co-ins, after ded	None
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	None
	Emergency medical transportation	0% co-ins, after ded	0% co-ins, after ded	Network Deductible applies.
	Urgent care	$50 copay per visit	30% 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)	0% co-ins, after ded	30% co-ins, after ded	Pre-certification required non-participating or benefit reduces by 20% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Physician/surgeon fee	0% co-ins, after ded	30% co-ins, after ded	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay per visit	30% co-ins, after ded	Partial hospitalization/intensive outpatient therapy: 0% co-ins, after ded Pre-certification required for certain services non-participating or benefit reduces by 20% of allowed.
	Mental/Behavioral health inpatient services	0% co-ins, after ded	30% co-ins, after ded	Pre-certificaton required non-participating or benefit reduces by 20% of allowed.
	Substance use disorder outpatient services	$25 copay per visit	30% co-ins, after ded	Partial hospitalization/intensive outpatient therapy: 0% co-ins, after ded Pre-certification required for certain services non-participating or benefit reduces by 20% of allowed.
	Substance use disorder inpatient services	0% co-ins, after ded	30% co-ins, after ded	Pre-certification required non-participating or benefit reduces by 20% of allowed.
If you are pregnant	Prenatal and postnatal care	No Charge	30% co-ins, after ded	Additional copays, deductibles, or co-ins may apply.
	Delivery and all inpatient services	0% co-ins, after ded	30% co-ins, after ded	Inpatient Notification may apply.
If you need help recovering or have other special health needs	Home health care	0% co-ins, after ded	30% co-ins, after ded	Limited to 60 visits per contract period. Pre-certification required non-participating or benefit reduces by 20% of allowed.
	Rehabilitation services	$25 copay per outpatient visit	30% co-ins, after ded	Limited to 20 visits per contract period except 36 visits for Cardiac therapy. Pulmonary therapy visits are not limited. Pre-certification required non-participating or benefit reduces by 20% of allowed.
	Habilitative services	$25 copay per outpatient visit	30% co-ins, after ded	Services provided under and limits are combined with Rehabilitation services above. Pre-certification required non-participating or benefit reduces by 20% of allowed.
	Skilled nursing care	0% co-ins, after ded	30% co-ins, after ded	Limited to 120 days per contract period. Pre-certification required non-participating or benefit reduces by 20% of allowed.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Durable medical equipment	0% co-ins, after ded	30% co-ins, after ded	Pre-certification required non-participating or benefit reduces by 20% of allowed. No coverage for repair/replace of damaged equipment.
	Hospice service	0% co-ins, after ded	30% co-ins, after ded	Pre-certification required non-participating or benefit reduces by 20% of allowed.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	No coverage for Eye exam.
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult/Child)
- 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.)

- Chiropractic care
- Hearing aids

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 Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or the Florida Department of Financial Services at 1-877-693-5236 or visit www.myfloridacfo.com.

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 1-800-782-3740

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-782-3740

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-782-3740

Navajo (Dine): Dinek'ehgo shika at' ohwol ninisingo, kwiijigo holne' 1-800-782-3740

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** $6,820
- **Patient pays** $720

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	$500
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$720**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,860
- **Patient pays** $1,540

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	$200
Copays	$1,300
Coinsurance	$0
Limits or exclusions	$40
Total	**$1,540**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by 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 **providers.** If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** 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.

Does the Coverage Example predict my own care needs?

✖ **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.

Does the Coverage Example predict my future expenses?

✖ **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 **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **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.

Are there other costs I should consider when comparing plans?

✓ **Yes** . An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. 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.

Questions: Call **1-800-782-3740** or visit us at **www.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 **www.cciio.cms.gov** or **www.dol.gov/ebsa/healthreform** or call **1-866-487-2365** to request a copy.

F0SU
25/500/0%
W/Direct Access Rider

NEIGHBORHOOD HEALTH PARTNERSHIP, Inc.
POS
SUMMARY OF BENEFITS

A quick glance at this Summary of Benefits will introduce you to the Point of Service (POS) Plan you have with Neighborhood Health Partnership, Inc. (NHP).
The Summary of Benefits, although a helpful tool, is only a summary. Always refer to your Member Handbook for a full explanation of your coverage or call Customer Service at the phone numbers on your health plan ID Card when you have a question about your plan. In the event of a conflict between this Summary of Benefits and the Handbook, the Handbook will control.
As a Member of the POS Plan, you are eligible to receive the HMO Benefit Level by accessing all of your care through your Primary Care Physician (PCP). In other words, if the health care services you receive are provided or arranged upon referral from your PCP, you are accessing your health care at your HMO Benefit Level. When obtaining Covered Services at your HMO Benefit Level, you will be responsible for paying the member cost share in this summary of benefits for Covered Services.

Important aspects of your POS Plan:

- In addition to direct access to certain Network Providers through your HMO Benefit, you may access other health care providers without a referral from your PCP.
- You may access Network Providers or Non-Network Providers.
- Your Benefit Level, Deductibles, Coinsurance and Out of Pocket Maximum are affected by whether you access a Network Provider or a Non-Network Provider under your POS Plan. For example: If your Physician is a Non-Network Provider, all related Covered Services will be paid at the POS Benefit Level, regardless of the status of other providers and facilities.
- Except for designated direct access services, when you access providers without a referral from your PCP, you are obtaining your healthcare services at the POS Benefit Level.
- Even when your Plan includes a POS Rider, you must select a PCP or NHP will assign one to you. If you need assistance, call Customer Service.

Features	**Please note: if your Plan has a deductible, the deductible must be satisfied unless otherwise specified. You are also responsible for any copayments and/or coinsurance listed below.**
Deductible	$500 per member, and/or $1,000 per family, whichever comes first. Individual deductible amounts will count toward the family deductible. However, an individual will not have to pay more than the individual deductible amount. Any deductible is on a calendar year basis.

Coinsurance	Benefits as defined below may be subject to a coinsurance of 0% once the calendar year deductible is met.
Out of Pocket Maximum	The limit which you and your eligible family members must pay in copayments (including Pharmacy Copayments) and coinsurance per calendar year is $1,500 per member and $3,000 per family. Individual Out of Pocket Maximum amounts will count toward the family Out of Pocket Maximum. However, an individual will not have to pay more than the individual Out of Pocket Maximum amount. Out of Pocket Maximum includes the Deductible. Out of Pocket Maximum includes amounts paid toward Pharmacy coinsurance.
Primary Care	Your PCP is responsible for coordinating all your health care services, including referrals to Specialists. Your PCP or Physician Specialist must obtain Prior-Authorization for designated services including, but not limited to all inpatient care, outpatient surgical procedures, durable medical equipment (DME), home health services, home infusion, hospice care, rehabilitation, skilled nursing facility and transplant services.
Referrals	Your PCP is responsible for coordinating all referrals to specialists, except for the following specialties which you may access directly: • Podiatry • Chiropractic • Dermatology (first 5 visits per calendar year). Additional visits require referrals. • Gynecology

Note: If your Employer purchased a Direct Access Rider, you may see a Specialist without a referral from your PCP. Please refer to your health plan ID Card or call Customer Service to verify the need to obtain a referral to a Specialist. Even when the Plan includes a Direct Access Rider, you must select a PCP or NHP will assign one to you. If you need assistance, call Customer Service.

Your Payments When You Access Services through Your POS Plan Note: No referrals are required for POS Benefits	
Deductible per calendar year	
Single coverage	$1,000
Family coverage	$2,000
Coinsurance	
For Non-Network Providers	30% of Eligible Expenses
Out of Pocket Maximum per calendar year	
Single coverage	$6,250
Family coverage	$12,500

YOUR NHP PLAN COVERAGE

IMPORTANT NOTICE: Unless otherwise stated, care, services or treatment not managed by your Primary Care Physician, not Medically Necessary, or not Prior Authorized by NHP are not considered to be HMO Benefit Level Covered Services. HMO Services must be provided by Network Providers, except when Prior Authorized or in the case of an Emergency Medical Condition.

You must check your Handbook for further details relating to your coverage.

Services & Supplies	Your Responsibility for HMO Benefits	Your Responsibility for POS Benefits
Allergy Testing	$25 copayment per visit	30% after deductible
Ambulance *(Non-emergency transportation must be authorized in advance by NHP.)*	0% after deductible in emergency situations or when authorized by NHP to transfer you to a NHP facility.	Benefits paid at the HMO Benefit Level in emergency situations or when authorized by NHP to transfer you to a NHP facility.
Applied Behavioral Analysis	**Note: Services must be provided by NHP's behavioral health network.** ***Outpatient***: $25 copayment per visit PCP referral not required. ***Inpatient:*** 0% after deductible	*Outpatient:* 30% after deductible *Inpatient:* 30% after deductible

Services & Supplies	Your Responsibility for HMO Benefits	Your Responsibility for POS Benefits
Autism Spectrum Disorder	Covered as any other eligible service, based on place of service.	30% after deductible
Bones or Joints of the Jaw and Facial Region	Covered as any other eligible service, based on place of service.	30% after deductible
Chiropractic Services *Combined HMO and POS coverage is limited to 20 treatments per calendar year. PCP referral is not required.*	$25 copayment per visit	30% after deductible
Dermatology	$25 copayment per visit PCP referral not required for 5 visits per calendar year; further visits require PCP referral.	30% after deductible
Diabetes	$25 copayment per visit Services include outpatient self-management training and educational services.	30% after deductible.
Durable Medical Equipment (DME) and disposable medical supplies, including breast pumps.	0% after deductible	30% after deductible
Emergency Room Services	$100 copayment per visit Any deductible and/or copayment for the emergency room is waived if the patient is admitted to the hospital.	Benefits paid at the HMO Benefit Level.
Enteral Formula	0% after deductible	Benefits accessed only through HMO Benefit Level.
Family Planning	Covered as any other eligible service, based on place of service. Limited to surgical sterilization, implantable contraceptives and intrauterine birth control devices.	30% after deductible
Gynecology	$25 copayment per visit PCP referral not required.	30% after deductible

Services & Supplies	Your Responsibility for HMO Benefits	Your Responsibility for POS Benefits
Hearing Aids *Combined HMO and POS coverage is limited to $2,500 per year and to a single purchase (including repair/ replacement) every three years.*	0% after deductible	30% after deductible
Hearing Exams *(children through age 21)*	No copayment when performed by PCP to determine need for hearing correction. Limited to one exam per calendar year.	Benefits accessed only through HMO Benefit Level.
Home Health Services *Combined HMO and POS coverage is limited to 60 visits per calendar year. Custodial care is not covered.*	0% after deductible Limited to 60 visits per calendar year.	30% after deductible
Home Infusion Services *Combined HMO and POS coverage is limited to 60 visits per calendar year.*	0% after deductible	30% after deductible
Hospice Care	0% after deductible	30% after deductible
Hospital Facility Care	***Inpatient:*** 0% after deductible ***Outpatient Facility - Surgical Procedures:*** 0% after deductible	*Inpatient:* 30% after deductible *Outpatient:* 30% after deductible
Minor Diagnostic/X-Ray and Laboratory Services	0%, deductible does not apply	30% after deductible.
Major Diagnostic Services, including CT, MRI, MRA, PET Scans and Nuclear Imaging	0% after deductible	30% after deductible
Mammography Screening	No copayment and not subject to any deductible.	No copayment and not subject to any deductible.

Services & Supplies	Your Responsibility for HMO Benefits	Your Responsibility for POS Benefits
Mastectomy	Covered as any other eligible service, based on place of service.	30% after deductible
Maternity Care, including pre- and post-natal care and delivery* Physician Office Services include one OB ultrasound between weeks 13 and 24 of pregnancy.	Covered as any other eligible service, based on place of service. Note: any office visit copayment applies only to the initial visit.	30% after deductible
Mental Health	**Note: Services must be provided by NHP's behavioral health network.** ***Outpatient***: $25 copayment per visit PCP referral not required. ***Partial Hospitalization***: 0% after deductible ***Inpatient***: 0% after deductible	*Outpatient:* 30% after deductible *Partial Hospitalization*: 30% after deductible *Inpatient:* 30% after deductible
Neurobiological Disorder Services – Autism Spectrum Disorder	**Note: Services must be provided by NHP's behavioral health network.** ***Outpatient***: $25 copayment per visit PCP referral not required. ***Partial Hospitalization***: 0% after deductible ***Inpatient***: 0% after deductible	*Outpatient:* 30% after deductible *Partial Hospitalization*: 30% after deductible *Inpatient:* 30% after deductible
Newborn Children* (birth – 30 days)	Covered as any other eligible service, based on place of service.	30% after deductible
Organ Transplant Inpatient Services	Covered as any other eligible service, based on place of service. Must be Prior Authorized by NHP Medical Director or designee.	30% after deductible
Osteoporosis	Covered as any other eligible service, based on place of service. Limited to diagnosis and treatment of high-risk individuals.	30% after deductible
Outpatient Therapies, including Habilitative Services *Combined HMO and POS coverage is limited to 20 visits per calendar year per modality except 36 visits for cardiac therapy.*	$25 copayment per visit	30% after deductible

Services & Supplies	Your Responsibility for HMO Benefits	Your Responsibility for POS Benefits
Physical Rehabilitation – Inpatient Care *Combined HMO and POS coverage is limited to 60 days per calendar year for restorative physical therapy.*	0% after deductible	30% after deductible
Physician Services	0% after deductible for inpatient care or outpatient surgical services when performed in an Inpatient setting or an Outpatient Facility.	30% after deductible
Podiatry	$25 copayment per visit PCP referral not required.	30% after deductible
Preventive Health Services	No Copayment and not subject to any Deductible.	Benefits accessed only through HMO Benefit Level, except for Child Health Supervision Services.
Primary Care Physician (PCP)	$25 copayment per visit Only applies to your designated PCP.	Benefits accessed only through HMO Benefit Level.
Prosthetic Devices	0% after deductible	30% after deductible
Skilled Nursing Facility *Combined HMO and POS coverage is limited to 120 days per calendar year. Custodial care is not covered.*	0% after deductible	30% after deductible
Specialist Office Visits	$25 copayment per visit PCP referral required unless direct access is allowed, as indicated.	30% after deductible
Sterilization	Covered as any other eligible service, based on place of service. Reversals are not covered.	30% after deductible
Substance Use Disorders	**Note: Services must be provided by NHP's behavioral health network.** ***Outpatient***: $25 copayment per visit PCP referral not required. ***Partial Hospitalization***: 0% after deductible ***Inpatient:*** 0% after deductible	*Outpatient:* 30% after deductible *Partial Hospitalization*: 30% after deductible *Inpatient:* 30% after deductible

Services & Supplies	Your Responsibility for HMO Benefits	Your Responsibility for POS Benefits
Therapeutic Treatments - Outpatient	0% after deductible	30% after deductible
Urgent Care Center	$50 copayment per visit	30% after deductible
Vision Screening *(children through age 21) Combined HMO and POS coverage is limited to services necessary to determine need for vision correction and to one exam per calendar year.*	No copayment when performed by PCP. Deductible does not apply	Benefits accessed only through HMO Benefit Level.

* For coverage to begin at the date of birth for newborn children, a completed and signed enrollment form must be received by NHP. When received within 30 days of birth; no additional premium will be charged for this 30 day period. When notice is received within 60 days from the date of birth, premium will be charged from the date of birth. If the enrollment form is not received within 60 days of birth, the newborn child will be considered a late enrollee. You must enroll your newborn within these time periods regardless of whether your coverage is family coverage.

Your Handbook and POS Rider have descriptions of benefits, including any limitations and exclusions.

You have coverage for Prescription Drugs only if your Group has elected to obtain a Prescription Drug Rider.

When accessing a Network Provider, NHP will pay based on the Plan's contracted rate; when accessing a Non-Network Provider, NHP will pay based on Eligible Expenses.

Please note that if you access a Non-Network Provider under your POS plan, the difference between Eligible Expenses and the Non-Network Provider's charge will be your responsibility.

PRIOR AUTHORIZATION REQUIREMENTS

Certain services require prior authorization by NHP. You are responsible for assuring that your treating physicians (Network Providers and Non-Network Providers) obtain the necessary prior authorizations for services and that they otherwise comply with applicable Utilization Review requirements.

FAILURE TO OBTAIN PRIOR AUTHORIZATIONS WILL RESULT IN A 20% DECREASE IN YOUR POS BENEFIT LEVEL

Prior authorization is required for any of the following services:

1. Inpatient: hospital (including observation), psychiatric, rehabilitation facility and skilled nursing facility
2. Surgery and invasive procedures: performed in an outpatient hospital or ambulatory facility (with the exception of Colonoscopies for customers 50 years of age and older and Sigmoidoscopies).
3. Implantable cardiac defibrillators, ventricular assist devices, and lung volume reduction surgery procedures, even if the inpatient admission has been authorized
4. All out of network and out of area services, except for emergencies.
5. MRI, MRA, CT Scans, PET scans
6. Sleep studies
7. Nuclear stress tests, including without limitation thallium, technetium, Cardiolite, Myoview, sestamibi; and myocardial perfusion and ejection fraction, and wall motion studies. Nuclear stress tests encompass nonpharmacological (exercise) and pharmacological stress tests, including without limitation, adenosine, persantine and dobutamine.
8. Invasive vascular studies and procedures/EP studies
9. Durable medical equipment, including insulin pumps and supplies
10. Prosthetic and orthotic devices
11. Home health care
12. Outpatient therapy: physical, occupational, speech and cardiac.
13. Hyperbaric oxygen treatment
14. Wound care
15. Mental Health, Substance Use Disorders and Neurobiological Disorders - Autism Spectrum Disorder Services
16. Dialysis
17. Chemotherapy (chemotherapeutic agents regardless of indication), radiation therapy, transfusions, infusions
18. Chronic specialist care
19. Pain management
20. Hospice
21. Biophysical profiles and amniocentesis
22. Laboratory services
23. Ambulance service, other than emergencies
24. Genetic Testing
25. Drugs: Botox, Epogen, Procrit, Lupron 11.25 mg, Prolastin, Remicaid, Synvisc/Hyalgan, Growth Hormone, Alferon, and Mifeprex

Neighborhood Health Partnership, Inc.

POINT-OF-SERVICE RIDER

As of the Effective Date and notwithstanding anything in the *Group Service Agreement* ("*Agreement*") to the contrary, this Point-of-Service Rider ("Rider") is made a part of the *Agreement* when elected by the Group and is noted on the Group's Application. The terms used in this Rider will have the same meaning as in the *Agreement,* unless otherwise stated.

POINT-OF-SERVICE PROGRAM

Members may choose to receive Covered Services from Network Providers without a referral or Non-Network Providers with or without a referral from the Primary Care Physician or NHP. All treatment and services provided by Network Providers or Non-Network Providers under this Rider are subject to the terms, conditions and limitations of the Agreement and this Rider. The purpose of this Rider is to allow a Member to access the services of a Network Provider without a referral or Non-Network Provider with or without a referral and does not otherwise alter, amend, revise or add benefits to those provided under the Agreement.

Please note the following:

- Even though a referral is not required, some services are subject to the Utilization Review Requirements of this Rider.
- When a Member receives Covered Services from a Network Provider without a referral, the Member will be subject to a higher amount of out-of-pocket expenses.
- If the Physician is a Non-Network Provider, all related Covered Services will be paid at the Non-Network Benefit Level, regardless of the status of other providers and facilities.
- When a Member accesses a Provider under this Rider, all related Covered Services are subject to the terms of this Rider.

Covered Services provided under this Rider are covered at the Benefit Level for Network Providers or Non-Network Providers, as applicable, after the Deductible has been satisfied. Point-of-Service Benefit Level for Network Providers is based on Network Providers' contracted rates. Point of Service Benefit Level for Non-Network Providers is based on Eligible Expenses. These Benefit Levels will be paid for Covered Services under this Rider until a Member's Out-of-Pocket Maximum is reached for any calendar year. After reaching the Out-of-Pocket Maximum, Covered Services will be paid under this Rider at 100% of the contracted rates for Network Providers or 100% of Eligible Expenses for Non-Network Providers for the remainder of that calendar year.

The Deductible, Benefit Level, Coinsurance and Out-of-Pocket Maximum for services provided by Network Providers are based on contracted rates and for Non-Network Providers are based on Eligible Expenses.

Utilization Review Requirements

The Point-of-Service program contains Utilization Review (UR) requirements. When the Member chooses a Network Provider or a Non-Network Provider under this Rider, services must be pre-certified by NHP according to NHP's UR requirements. The Member is responsible for assuring that his/her treating providers (Network Providers or Non-Network Providers) obtain all necessary prior authorization for services and that they otherwise comply with applicable UR requirements.

Failure to obtain prior authorization will result in a reduction in the applicable Benefit Level by 20 percentage points. Additionally, any amounts paid by the Member as a result of failure to obtain the required prior authorization will not be applied to any Deductible or Out-of-Pocket Maximum amounts.

In order to obtain prior authorization, NHP must be notified at least 10 business days before you obtain services, or as soon as possible. Since NHP changes the list of services and supplies requiring prior authorization from time to time, please call Customer Service at the phone number on your ID card or access the list on our website at www.myNHP.com prior to obtaining the service or supplies. This notification requirement does not apply to an Emergency Medical Condition.

Deductible Credit

If a Member was covered under the Group's prior group health plan on the day prior to the Effective Date of the *Agreement*, any Covered Services which were:

1. incurred under the prior plan;
2. incurred during the same calendar year as the Effective Date of the *Agreement*; and
3. credited towards the Member's deductible under the prior plan,

will also be credited towards that Member's Deductible under this Rider for the calendar year in which the Effective Date of the *Agreement* occurs.

It is the Member's responsibility to provide information regarding this deductible credit to NHP within 30 days after the Effective Date of the *Agreement*. Amounts reported to NHP more than 30 days after the Effective Date of the *Agreement* will not be credited. Any Deductible or Out-of-Pocket Maximum amounts satisfied in a calendar year will not be carried over to the next calendar year.

Definitions

The following definitions pertain to Covered Services received under this Rider:

Benefit Level means: (a) for Network Providers that percentage of the contracted rate shown in the *Summary of Benefits*; or (b) for Non-Network Providers, that percentage of Eligible Expenses shown in the *Summary of Benefits*. After the Deductible is met, NHP will pay the Benefit Level, as applicable, for Covered Services under this Rider until the Out-of-Pocket Maximum is reached.

Billed Charges means that dollar amount billed by a Network, POS Plus or Non-Network Provider for treatment, services or supplies rendered.

Coinsurance means: (a) for Network Providers, the percentage of the contracted rate for which the Member is responsible to pay; or (b) for Non-Network Providers, the percentage of Eligible Expenses for which the Member is responsible to pay towards Covered Services.

Deductible means that dollar amount of Covered Services as shown in the *Summary of Benefits*, for which a Member is responsible to pay each calendar year before the applicable Benefit Level is payable under this Rider. Such amounts are not reimbursed by NHP. After the Deductible amount has been paid, benefits for Covered Services under this Rider will be payable at the applicable Benefit Level. For Network Providers, the Deductible is based on contracted rates. For Non-Network Providers, the Deductible is based on Eligible Expenses.

Eligible Dependent under this Rider does not include any spouse or child who:

- Resides outside the state of Florida;
- Spends more than 180 consecutive days for any reason, outside the United States in any calendar year,
- Is in the military forces of any country; or
- Is an Eligible Employee employed by the Group.

Eligible Employee under this Rider does not include any person who:

- Resides outside the state of Florida;
- Spends more than 180 consecutive days for any reason, outside the United States in any calendar year, or
- Is a seasonal or temporary employee.

Eligible Expenses means the amount determined, at our discretion, to be the basis for Covered Services from Non-Network Providers. The amount is based on the lesser of:

- Fees that are negotiated with the Non-Network Provider
- 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service [within the geographic market]
- 50% of the Billed Charges
- A fee schedule that we develop.

Non-Network Provider means Hospitals, Physicians and other providers of health care goods and services who have not contracted with NHP to provide Covered Services to its Members.

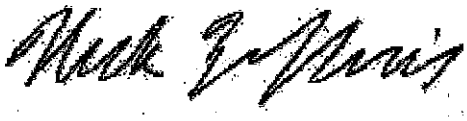
Out-of-Pocket Maximum means the sum total of Deductible arid Coinsurance amounts that a Member is responsible to pay for Covered Services in a calendar year. This amount is shown in the *Summary of Benefits*.

Point-of-Service means a health plan under which the Member has the right to receive Covered Services from a Network Provider without referral, or a Non-Network Provider with or without referral.

Rider means this Point-of-Service Rider.

Please call Customer Service at 1-877-972-8845 for assistance regarding claims, resolving a complaint or information about Benefits and coverage.

NEIGHBORHOOD HEALTH PARTNERSHIP, INC.



Chief Executive Officer
South Florida Health Plan

UnitedHealthcare®
Neighborhood Health Partnership

DIRECT ACCESS RIDER

As of the Effective Date, and notwithstanding anything in the Group Service Agreement ("Agreement") to the contrary, the following Direct Access Rider is hereby made a part of the Agreement if elected by the Group and such election is evidenced in the Group's Application for Group Service Agreement. The terms used in this Rider shall have the same meaning ascribed thereto or used in the Agreement, unless otherwise stated herein.

DIRECT ACCESS PROGRAM

A Member with a Direct Access Rider has the right to elect to visit an NHP Specialist without a referral from the Primary Care Physician or Plan ("Direct Access Visit(s)"). Direct Access Visits are subject to the terms and conditions of the Agreement and this Direct Access Rider. All services and treatment rendered to the Member by a NHP Specialist during or in connection with a Direct Access Visit are subject to NHP's Utilization Review (UR) requirements and the Agreement, except as may be stated otherwise in this Rider. A Direct Access Visit includes services and treatment received from an NHP Specialist, so long as such services do not require pre-certification from NHP. Those services which require pre-certification under the Plan's UR requirements require pre-certification on a Direct Access Visit.

NEIGHBORHOOD HEALTH PARTNERSHIP, INC.

Nicholas J. Zaffiris
CEO
South Florida Health Plans

20/40/60

Prescription Drug Benefit

SUMMARY OF BENEFITS

A quick glance at this Summary of Benefits will introduce you to your prescription drug benefits at Neighborhood Health Partnership (NHP) HMO. You only have a prescription drug benefit if your group elected to purchase this coverage.

The Neighborhood Health Partnership (NHP) group plans include a prescription drug benefit that features a tiered structure. This offers you more flexibility when making decisions about your prescription drug purchases.

COPAYMENT PER PRESCRIPTION ORDER OR REFILL: Your Copayment is determined by the tier NHP has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.mynhp.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits. All prescription drugs must be obtained from a Plan Retail Network Pharmacy or Plan Home Delivery Network Pharmacy and must be medically necessary for the care and treatment of an illness or injury.

Annual Drug Deductible	
Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Maximum	
Individual Out-of-Pocket Maximum	See Medical Benefit Summary
Family Out-of-Pocket Maximum	See Medical Benefit Summary

Tier Level	Retail Up to 31-day supply	*Mail Order Up to 90-day supply
	Network	**Network**
Tier 1	$20	$40
Tier 1 Specialty	$20	Not Covered
Tier 2	$40	$80
Tier 2 Specialty	$125	Not Covered
Tier 3	$60	$120
Tier 3 Specialty	$250	Not Covered

UnitedHealthcare
Neighborhood Health Partnership

HM33660N 1/16
Rx Summary AL-14
213-8018

Growth Hormone Therapy	30% of the Prescription Drug Cost.

*Only certain Prescription Drug Products are available through mail order; please visit www.mynhp.com or call Customer Care at the telephone number on the back of your ID card for more information.

RETAIL NETWORK PHARMACY: Prescription drugs may be dispensed up to a 30-day supply by a retail Plan pharmacy. Oral contraceptives may be dispensed for up to three cycles (upon payment of three copayments).

HOME DELIVERY NETWORK PHARMACY: Prescription drugs may be dispensed up to a 90-day supply by mail-order pharmacy.

UTILIZATION REVIEW

Drug utilization review and clinical review programs are used to monitor the dosage and treatment patterns for Members covered under this Agreement. Under these programs, the Plan may limit or otherwise restrict the quantity or type of drug for which the Plan will provide a benefit based upon the cost of the drug prescribed by your Provider, clinical indications and other factors. Drugs that are subject to utilization review programs are not Covered Prescription Drugs unless the requirements of the Plan's utilization review and/or clinical programs, and all of the other terms and conditions set forth in this Agreement are met. Drugs that are subject to utilization review and clinical review programs always require the Plan's prior authorization before they will be covered. The list of drugs that require prior authorization may be amended by the Plan from time to time.

Your Prescription Rider lists the exclusions, limitations and restrictions which apply.

The Summary of Benefits, although a helpful tool, is only a summary. If you have specific questions about pharmacy management procedures or whether a specific drug is covered, please call our Customer Service Department at 1-877-972-8845 or 711 for the hearing impaired. Always refer to your Prescription Drug Rider for a more-detailed explanation of your drug coverage.

How to find a doctor or hospital in our network

Two ways to search and save.

Use doctors, hospitals, pharmacies, labs and other providers and facilities in our network to help lower your health care costs. Here are two ways to start your search.

Go online

If you are not a member

1. Visit **welcometouhc.com**
2. Select **Find a Doctor.**
3. Select your health plan.
4. On the next screen, enter a doctor name, facility name, specialty or condition. You can even search by distance, gender, language and more.

If you are a member

1. Log in to **myuhc.com®**
2. Select **Find a Doctor** or **Physicians & Facilities.**
3. Select **Find a Provider.** On the next screen, enter a doctor name, facility name, specialty or condition. You can even search by distance, gender, language and more.

Personalize your search

You can find doctors who best match your health needs, including doctors who are treating people with similar health concerns and conditions.

Call us

A customer care professional will be happy to help you with your doctor search. Call **1-866-873-3903.** If you are a member, you can also call the number on the back of your health plan ID card.

What is a "network"?
A network is a group of doctors, hospitals and other providers and facilities that have a contract with UnitedHealthcare. As part of their contract, they have agreed to follow our guidelines and provide health care services to you at lower prices.

Why is this important?
You can save money. For example, when you use a network doctor, you will usually pay less compared to seeing a doctor who is out-of-network.

UnitedHealthcare®

Choose with confidence.

The UnitedHealth Premium® designation program makes it easy for you to find network doctors who meet national standards for quality and local market benchmarks for cost efficiency. Review your options and **choose a doctor with confidence.**

Learn more at **UnitedHealthPremium.com.**

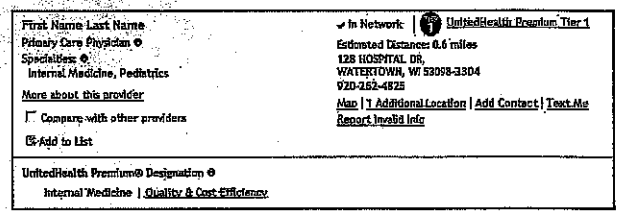
The choice is yours.

The UnitedHealth Premium program can help you find the care you want. The program evaluates doctors in 25 different medical specialties, using national standards for quality and local benchmarks for cost efficiency. You can use this information to help you choose the care that's right for you.

Make the most of your benefits.

TIER 1

Members in health plans that offer tiered benefits may pay lower co-payments and co-insurance amounts for services provided by UnitedHealth Premium Tier 1 physicians.



Possible designations a doctor can receive

The chart shows the two possible designations a doctor can receive to be a Tier 1 physician. It also shows the designation if a doctor meets one criteria but not the other."

UnitedHealth Premium Designation	Meets quality criteria	Meets cost efficiency criteria	UnitedHealth Premium Tier 1
Quality & Cost Efficiency	✓	✓	✓
Cost Efficiency & Not Enough Data to Assess Quality	Not enough data to measure.	✓	✓
Quality & Not Enough Data to Assess Cost Efficiency	✓	Not enough data to measure.	
Quality & Did Not Meet Cost Efficiency	✓		

If a doctor does not have a Premium designation, it does not mean he or she provides a lower standard of care. It could mean that the data available to us was not sufficient to include the doctor in the program. All doctors who are part of the UnitedHealthcare network must meet our credentialing requirements (separate from the Premium program).

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The UnitedHealth Premium® designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com®. You should always visit myuhc.com for the most current information. Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician. Please visit myuhc.com for detailed program information and methodologies.

Only individual physicians that meet UnitedHealth Premium designation criteria, or physicians in designated specialties who are part of medical groups that meet UnitedHealth Premium criteria for group practices and who have sufficient claims data for analysis, may be designated. All physicians that contract with UnitedHealthcare have met credentialing requirements. Regardless of designation, plan enrollees have access to physicians in the UnitedHealthcare network as described in their benefit plan. Specialties for which there are no quality guidelines currently established in the program are excluded from evaluation and are noted as such.

The assessment result "Not Enough Data to Assess" is not an indicator of the total number of patients treated by the physician or the number of procedures performed by the physician. Rather, it reflects the statistical requirements of the Premium designation program, which includes only health plan claims associated with specific program measures and relevant to the physician's designated specialty. In some cases, there may not be enough data to complete the analytic process from a statistical standpoint.

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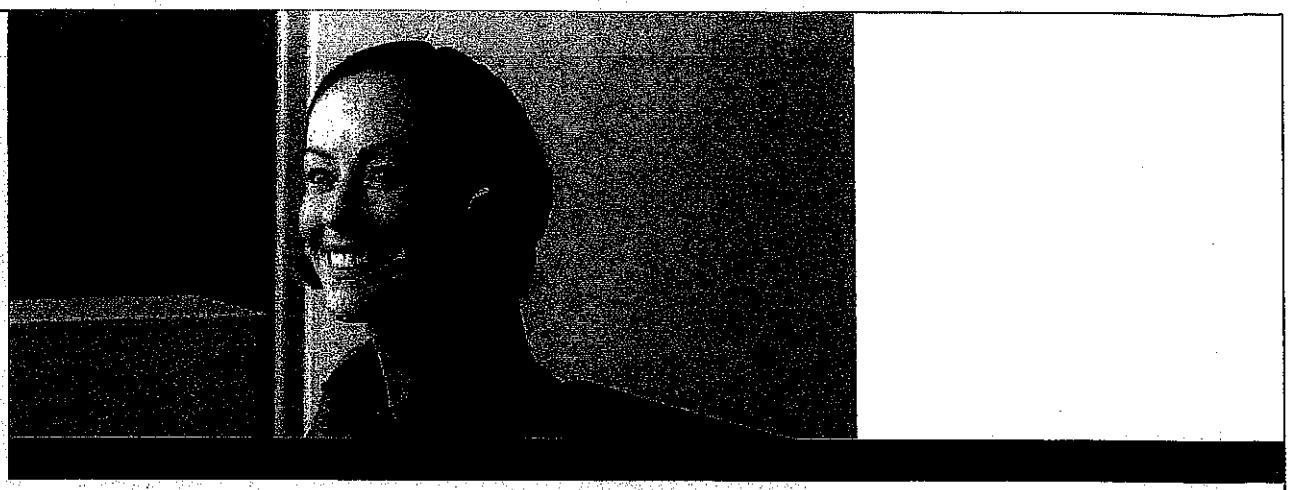

myNurseLine℠

When you have a health concern, it can be difficult and time-consuming to find the information you need. myNurseLine can help you make smart health care decisions with immediate telephone and **online access** to experienced registered nurses.

Your health advocate

One toll-free number connects you with a registered nurse who will take the time to understand what is going on with your health and provide personalized information that is right for you. And this is all available **24 hours a day, seven days a week,** at no additional cost to you. It is included in your benefits.

myNurseLine also give you access to an audio health information library. Choose from more than 1,100 health and well-being topics, with 600 messages available in Spanish. Services are available to translate 140 languages and for callers with hearing impairments.

Experience you can rely on

myNurseLine nurses have an average of 15 years clinical nursing experience. They are an excellent resource when you need help choosing care, managing a chronic condition, understanding treatment options and more.

Your one-stop source

Whether you have a baby with a 102 temperature at midnight or need help managing your diabetes, myNurseLine is the one source to give you the answers you need.

Not sure if you need a doctor, urgent care clinic or just some good health advice? One call to myNurseLine can help you get information about the care and services you need. So, think of myNurseLine as your one-stop resource to help you make smart health care decisions every day.

To talk with a myNurseLine nurse, call the Customer Care number on the back of your health plan ID card, or visit **myuhc.com®**.

My health, my questions, **myNurseLine.**

myNurseLine can help you:

- Chat with a nurse live on **myuhc.com**
- Understand treatment options
- Ask medication questions
- Choose appropriate medical care
- Locate available local resources
- Find a doctor, hospital or specialist and check if a doctor is in your network and is accepting new patients. We may even be able to make the appointment for you.

UnitedHealthcare Insurance Company

UnitedHealthcare®

For informational purposes only. Nurses cannot diagnose problems or recommend specific treatment and are not a substitute for your doctor's care. These services are not an insurance program and may be discontinued at any time. MyNurseLine is a service mark of UnitedHealth Group Incorporated.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

100-3501 9/11 Consumer © 2011 United HealthCare Services, Inc.

Health discount program. Be healthy. Save money.

Would you like to look better, feel better and save money?

Even if you already have medical, dental and vision coverage, as an enrolled health plan member, you can save even more money by using your health discount program.

Our health discount program helps you and your family save typically 10 to 25 percent on many health and wellness purchases not included in your standard health benefit plan. By visiting a participating health provider, you can save on:

- **Dental care** — Cosmetic procedures such as teeth whitening
- **Vision care** — Laser eye surgery
- **Alternative care** — Acupuncture, chiropractic care, massage therapy and natural medicine
- **Long-term care services** — Skilled nursing facilities, assisted living, respite programs and durable medical equipment
- **Infertility treatment**
- **Hearing devices**

UnitedHealthcare®

Disclosure: The UnitedHealth Allies® discount plan is administered by HealthAllies®, Inc., a discount medical plan organization. The **UnitedHealth Allies discount plan is NOT insurance.** The discount plan provides discounts at certain health care providers for health services. The discount plan does not make payments directly to the providers of health services. The discount plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization. HealthAllies, Inc., is located at P.O. Box 10340, Glendale, CA, 91209, 1-800-860-8773.

So many ways to save

Save on these wellness resources to help you live a healthier life:

- Weight management from Jenny Craig®[1], Nutrisystem® and other popular programs
- Nutrition counseling
- Fitness clubs[2] including Anytime Fitness®, Curves®, Gold's Gym®, Jazzercise®, Life Time Fitness®, MyGym® and Snap Fitness®
- Fitness equipment and apparel
- Natural products and foods
- Stress reduction and relaxation resources
- Smoking cessation programs

[1] Plus the cost of food and shipping where applicable. Discounts apply to membership fee only. Offer good at participating Centres and Jenny At Home in the United States.

[2] Availability varies by geographic area; applies to new memberships only

How to get your discounts

Remember to always use your health benefits for covered services, and use the health discount program for those services that you must pay for yourself. No referrals are required for the health discount program, and there are no claim forms to submit. To locate participating health care professionals, programs and online retailers:

- Link to the health discount program from **myuhc.com®**, look for the **Extra Programs and Discounts*** link on the home page, or select the Physicians & Facilities tab and and choose Find Health and Wellness Discounts in the left navigation list.
- To search for a provider, program or online retailer, click the UnitedHealth Allies link and select a category (such as Alternative Care) and a specialty (such as Massage).
- For individual providers: Click **Select This Provider** to generate a discount confirmation. **Be sure to print the discount confirmation and take it with you to your appointment.** Note that the confirmation is simply your rate guarantee. You are under no obligation to visit the selected provider.
- Make an appointment, being sure to identify yourself as a UnitedHealth Allies® discount program member, and pay the discounted rate at the time of service.
- For national providers such as weight loss programs or our online shopping partners: Simply follow the instructions on the **Provider Profile** page to purchase products or services at the discounted rate. No confirmation is necessary.

*After logging in to **myuhc.com** and linking to the health discount site, if you are not automatically logged in to the health discount program website, click on **First-time users: Create Account** and follow the instructions. Or, call the Customer Care number on your medical ID card (or discount card, if issued).

Why pay full price for your out-of-pocket health care? Use the health discount program and save.

Savings examples based on fee schedules and contracted discount rates. Your actual savings may vary by provider or facility selected, geographic area and service purchased.

UnitedHealthcare®

Components subject to change. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

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Enrollment Application/Change/Cancellation Request

UnitedHealthcare
A UnitedHealth Group Company

☐ Enroll
☐ Cancel
☐ Change

☐ Address Change
☐ Name Change
Date of Change___/___/___

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation	**Reporting Code**	**Benefit Level/Class Code, if applicable**
Medical _____ Vision _____ Dental _____ Life _____	Medical _____ Vision _____ Dental _____ Life _____	Life/AD&D _____ Suppl. Life _____ Spouse Life _____ Suppl. AD&D _____

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___/___/___ Requested Date of Coverage ___/___/___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State Continuation start date _____ stop date_____
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___/___/___

☐ **Cancellations:** Last Date of Employment ___/___/___
Requested Effective Date of Cancellation ___/___/___
☐ Cancel all coverage
☐ Cancel all listed below – Section B
☐ Dependent reached maximum age
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe)_____

Employee Type ☐ Union ☐ Non-union ☐ Salaried ☐ Hourly ☐ Active ☐ Retire Date _____ ☐ COBRA/State Cont.

Signature _____ Date _____

A. Employee Information

Employer Position_____ Phone Number_____

Last Name	First Name	MI	Social Security Number	Home Phone Work Phone

Address	Apt #	City	State	Zip Code	Email Address

Date of Birth / /	Sex ☐ M ☐ F	Physician* (First & Last Name) / Physician's ID Number	Primary Care Dentist Number*

Marital Status
☐ Single ☐ Married
☐ Divorced ☐ Widowed

Race – Check all that apply (Optional)**
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____

*IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

**Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical Entities should be as follows: UnitedHealthcare Insurance Company or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.
Dental coverage provided by UnitedHealthcare Insurance or UnitedHealthcare of Florida, Inc. or Neighborhood Health Partnership, Inc.
Life Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name First Name MI / Social Security Number	Sex	Relationship**	Birthdate	Physician*(First and Last Name) Physician's ID Number
☐ Enroll ☐ Cancel ☐ Change		M F	Spouse		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)* ** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*

* IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

*** Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	☐	☐	☐	☐ $_____	☐	☐	☐	☐	
Spouse	☐	☐	☐	☐					
Dependents	☐	☐	☐	☐ Salary _____ Required only if Life Plan based on salary					

Life Insurance Beneficiary's Full Name and Address

Relationship

D. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

Primary Language Spoken ☐ English ☐ Spanish ☐ Other _____

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at **www.myuhc.com** or the at toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.