


**Benefit Summary
ASO Choice Plus**

Florida Municipal Insurance Trust HSA Medical Plan 5

United HealthCare Services, Inc. and Florida Municipal Insurance Trust want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com**[®] - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible – Combined Medical and Pharmacy		
Single Coverage Deductible	\$1,300 per year	\$2,500 per year
Family Coverage Deductible	\$2,600 per year	\$5,000 per year
Out-of-Pocket Maximum – Combined Medical and Pharmacy		
Single Coverage Out-of-Pocket Maximum	\$3,750 per year	\$7,500 per year
Family Coverage Out-of-Pocket Maximum	\$7,500 per year	\$15,000 per year
<ul style="list-style-type: none"> • The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum. 		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	90% after Deductible has been met	70% after Deductible has been met
Prescription Drug Benefits		
<ul style="list-style-type: none"> • Prescription drug benefits are shown under separate cover. Benefits are not payable for Prescriptions until the Deductible above has been met. 		
Information of Pre-service Notification		
<i>*Prior Authorization is required for certain services. (Note that only genetic testing for BRCA requires prior authorization for Non-Network services under the Physician's Services category)</i> <i>**Prior Authorization is required for Equipment in excess of \$1,000.</i>		
Information on Benefit Limits		
<ul style="list-style-type: none"> • The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category. 		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Dental Services – Accident Only		
	* 90% after Deductible has been met	* 90% after Network Deductible has been met
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	90% after Deductible has been met	** 70% after Deductible has been met
Emergency Health Services - Outpatient		
	90% after Deductible has been met	* 90% after Network Deductible has been met

SFXGFTT07PA

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Hearing Aids		
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	90% after Deductible has been met	70% after Deductible has been met
Home Health Care		
Benefits are limited as follows: 60 visits per year	90% after Deductible has been met	* 70% after Deductible has been met
Hospice Care		
	90% after Deductible has been met	* 70% after Deductible has been met
Hospital – Inpatient Stay		
	90% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	90% after Deductible has been met	* 70% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	90% after Deductible has been met	70% after Deductible has been met
Mental Health Services		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	90% after Deductible has been met	70% after Deductible has been met
Physician Fees for Surgical and Medical Services		
	90% after Deductible has been met	70% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	90% after Deductible has been met	* 70% after Deductible has been met
Specialist Physician Office Visit	90% after Deductible has been met	* 70% after Deductible has been met
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	
		<i>Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	Non-Network Benefits are not available
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	90% after Deductible has been met	** 70% after Deductible has been met
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		<i>Prior Authorization is required.</i>
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of manipulative treatment 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy The limits stated above include habilitative services.	90% after Deductible has been met	* 70% after Deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited	90% after Deductible has been met	70% after Deductible has been met

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.		
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	90% after Deductible has been met	* 70% after Deductible has been met
Substance Use Disorder Services		
	Inpatient: 90% after Deductible has been met Outpatient: 90% after Deductible has been met	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Surgery – Outpatient		
	90% after Deductible has been met	* 70% after Deductible has been met
Transplantation Services		
	* 90% after Deductible has been met	Non-Network Benefits are not available
	<i>For Network Benefits, services must be received at a Designated Facility.</i>	
Urgent Care Center Services		
	90% after Deductible has been met	70% after Deductible has been met

MEDICAL EXCLUSIONS
It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.
Alternative Treatments
Acupuncture; aromatherapy; hypnosis; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.
Dental
Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.
Devices, Appliances and Prosthetics
Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded; blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.
Drugs
The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by United HealthCare Services, Inc.), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.
Experimental or Investigational or Unproven Services
Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.
Foot Care
Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.
Medical Supplies and Equipment
Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to: <ul style="list-style-type: none"> • Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD. • Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD. • Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD. Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.
Mental Health / Substance Use Disorder
Services performed in connection with conditions not classified in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental retardation as a primary diagnosis defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozocine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
Nutrition
Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.
Personal Care, Comfort or Convenience
Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.
Physical Appearance
Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat

accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss.

Procedures and Treatments

Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; cranosacral therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chelation therapy, except to treat heavy metal poisoning.

Providers

Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.

Reproduction

Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactively disorder; TBI; or dyslexia.

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug up to the stated supply limit. Some Prescription Drugs are subject to additional supply limits

Some Prescription Drug or Pharmaceutical Products for which Benefits are described under the Prescription Drug section of the Summary Plan Description (SPD) are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Product(s) first.

Also note that some Prescription Drugs require that you notify us in advance to determine whether the Prescription Drug meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Pharmacy Exclusions

Exclusions from coverage listed in the SPD apply also to this Prescription Drug section. In addition, the following exclusions apply:

Exclusions

- Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drugs dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined to be experimental, investigational or unproven, unless United HealthCare Services, Inc. and the Florida Municipal Insurance Trust have agreed to cover.
- Prescription Drugs furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drugs for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in the Summary Plan Description (SPD). This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drugs.
- Medications used for cosmetic purposes.
- Prescription Drugs, including New Prescription Drugs or new dosage forms, that Florida Municipal Insurance Trust determine do not meet the definition of a Covered Health Service.
- Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- Prescription Drugs when prescribed to treat infertility.
- Certain Prescription Drugs for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.
- Certain New Prescription Drugs and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- A Prescription Drug that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug.
- A Prescription Drug that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.

-
- A Prescription Drug typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo provera and other injectable drugs used for contraception.
 - Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.


**Benefit Summary
ASO Choice Plus**

Florida Municipal Insurance Trust Medical Plan 14

United HealthCare Services, Inc. and Florida Municipal Insurance Trust want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com**[®] - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and more.
- **24-hour nurse support** – A nurse is a phone call away and you have other health resources available 24-hours a day, 7 days a week to provide you with information that can help you make informed decisions. Just call the number on the back of your ID card.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	\$1000 per year	\$1,000 per year
Family Deductible	\$2000 per year	\$2,000 per year
<ul style="list-style-type: none"> • Member Copayments do not accumulate towards the Deductible 		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	\$4000 per year	\$6,000 per year
Family Out-of-Pocket Maximum	\$8000 per year	\$12,000 per year
<ul style="list-style-type: none"> • The Out-of-Pocket Maximum includes the Annual Deductible. • Copayments, Coinsurance and Deductibles accumulate towards the Out-of-Pocket Maximum. • Prescription Drug cost shares are included in the Medical Out-of-Pocket Maximum. 		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	80% after Deductible has been met	70% after Deductible has been met
Prescription Drug Benefits		
<ul style="list-style-type: none"> • Prescription drug benefits are shown under separate cover. 		
Information of Prior Authorization		
*Prior Authorization is required for certain services. (Note that only genetic testing for BRCA requires prior authorization for Non-Network services under the Physician's Services category)		
**Prior Authorization is required for Equipment in excess of \$1,000.		
Information on Benefit Limits		
<ul style="list-style-type: none"> • The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • Refer to your Summary Plan Description for a definition of Eligible Expenses and information on how benefits are paid. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category. 		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 80% after Deductible has been met	* Same as Network
Dental Services – Accident Only		
	* 80% after Deductible has been met	* Same as Network
Durable Medical Equipment (DME)		
Benefits are limited as follows: A single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums.	80% after Deductible has been met	** 70% after Deductible has been met
Emergency Health Services - Outpatient		
	100% after you pay a \$200 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	* 100% after you pay a \$200 Copayment per visit

SFXGM TTT07PA

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Hearing Aids		
Benefits are limited as follows: \$2,500 per year and are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	80% after Deductible has been met	70% after Deductible has been met
Home Health Care		
Benefits are limited as follows: 60 visits per year	80% after Deductible has been met.	* 70% after Deductible has been met
Hospice Care		
	80% after Deductible has been met.	* 70% after Deductible has been met
Hospital – Inpatient Stay		
	80% after Deductible has been met.	* 70% after Deductible has been met
Lab, X-Ray and Diagnostics - Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	100% Deductible does not apply.	* 70% after Deductible has been met
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient		
	80% after Deductible has been met	70% after Deductible has been met
Mental Health Services		
	Inpatient: 80% after Deductible has been met Outpatient: 100% after you pay a \$25 Copayment per visit	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
	Inpatient: 80% after Deductible has been met Outpatient: 100% after you pay a \$25 Copayment per visit	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Pharmaceutical Products - Outpatient		
This includes medications administered in an outpatient setting, in the Physician's Office or in a Covered Person's home.	100% Deductible does not apply	70% Deductible does not apply
Physician Fees for Surgical and Medical Services		
	80% after Deductible has been met	70% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	100% after you pay a \$25 Copayment per visit	* 70% after Deductible has been met
Specialist Physician Office Visit	100% after you pay a \$50 Copayment per visit	* 70% after Deductible has been met

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary.	
	For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	<i>Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.</i>
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100% Deductible does not apply.	Non-Network Benefits are not available
Specialist Physician Office Visit	100% Deductible does not apply.	
Lab, X-Ray or other preventive tests	100% Deductible does not apply.	
Prosthetic Devices		
Benefits are limited as follows: A single purchase of each type of prosthetic device every three years.	80% after Deductible has been met	** 70% after Deductible has been met
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
		<i>Prior Authorization is required for certain services.</i>
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
Benefits are limited as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of manipulative treatment 20 visits of speech therapy 20 visits of pulmonary rehabilitation 36 visits of cardiac rehabilitation 30 visits of post-cochlear implant aural therapy 20 visits of cognitive rehabilitation therapy The limits stated above include habilitative services.	80% after Deductible has been met	* 70% after Deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	80% after Deductible has been met	70% after Deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days per year	80% after Deductible has been met	* 70% after Deductible has been met
Substance Use Disorder Services		
	Inpatient: 80% after Deductible has been met Outpatient: 100% after you pay a \$25 Copayment per visit	* Inpatient: 70% after Deductible has been met * Outpatient: 70% after Deductible has been met
Surgery – Outpatient		
	80% after Deductible has been met	* 70% after Deductible has been met
Transplantation Services		
	* 80% after Deductible has been met <i>For Network Benefits, services must be received at a Designated Facility.</i>	Non-Network Benefits are not available
Urgent Care Center Services		
	100% after you pay a \$35 Copayment per visit	70% after Deductible has been met

MEDICAL EXCLUSIONS
It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.
Alternative Treatments
Acupressure; aromatherapy; hypnolism; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the SPD.
Dental
Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-

related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.
Devices, Appliances and Prosthetics
Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part as described under Durable Medical Equipment (DME) in the SPD. Examples include foot orthotics, cranial banding, or any orthotic braces available over-the-counter. The following items are excluded; blood pressure cuff/monitor; enuresis alarm; non-wearable external defibrillator; trusses; and ultrasonic nebulizers. Devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.
Drugs
The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by United HealthCare Services, Inc.), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.
Experimental or Investigational or Unproven Services
Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.
Foot Care
Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports.
Medical Supplies and Equipment
Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: compression stockings; ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to: <ul style="list-style-type: none"> • Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD. • Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD. • Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD. Tubings, nasal cannulas, connectors and masks, except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD.
Mental Health / Substance Use Disorder
Services performed in connection with conditions not classified in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following: not consistent with generally accepted standards of medical practice for the treatment of such conditions; not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental; not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or not clinically appropriate, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks. Mental Health Services as treatments for V-code conditions as listed within the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning; tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act. Learning, motor skills and primary communication disorders as defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Mental retardation as a primary diagnosis defined in the current edition of the <i>Diagnostic and Statistical Manual of the American Psychiatric Association</i> . Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozine, or their equivalents for drug addiction. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
Nutrition
Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Diabetes Services in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.
Personal Care, Comfort or Convenience
Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.
Physical Appearance
Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss, except for temporary loss of hair resulting from treatment of a malignancy.
Procedures and Treatments
Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychotherapy. Sex transformation operations and related services. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Manipulative treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Manipulative treatment (the therapeutic application of chiropractic and osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be dental in nature, the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniocervical therapy; orthodontics; occlusal adjustment; dental restorations. Upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. Orthognathic surgery (procedure to correct underbite or overbite) and jaw alignment. Breast reduction except surgery as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. Chelation therapy, except to treat heavy metal poisoning.
Providers
Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.
Reproduction
Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.

Services Provided under Another Plan

Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

Transplants

Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD unless United HealthCare Services, Inc. determines the transplant to be appropriate according to United HealthCare Services, Inc.'s transplant guidelines. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

Health services provided in a foreign country, unless required as Emergency Health Services. Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described in the SPD.

Types of Care

Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain. Custodial care; domiciliary care. Private Duty Nursing. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the SPD. Rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Bone anchored hearing aids except when either of the following applies: for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid or for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Eye exercise or vision therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following: Medically Necessary; described as a Covered Health Service in the SPD; and not otherwise excluded in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of education, school, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described in the SPD. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Foreign language and sign language services. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service. For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactive disorder; TBI; or dyslexia.



Benefit Summary
Outpatient Prescription Drug

Florida Municipal Insurance Trust Pharmacy Plan

*This document is provided as a sample and does not reflect actual benefits.
 A customized Benefit Summary will be created during implementation of the business.*

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug. All Prescription Drugs on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.myuhc.com® or calling Customer Care at the telephone number on the back of your ID card

This summary of Benefits is intended only to highlight your Benefits for Prescription Drugs and should not be relied upon to determine coverage. Your plan may not cover all of your Prescription Drug expenses. Please refer to the Prescription Drug section of the Summary Plan Description (SPD) for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Prescription Drug section of the SPD, the Prescription Drug section of SPD shall prevail.

Annual Drug Deductible – Network and Non-Network

Individual Deductible	\$0
Family Deductible	\$0

Out-of-Pocket Drug Maximum – Network and Non-Network

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	Non-Network	Network
Tier 1	\$10	\$10	\$25
Tier 2	\$35	\$35	\$87.50
Tier 3	\$60	\$60	\$150

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

An Ancillary Charge may apply when a covered Prescription Drug is dispensed at your [or your provider's] request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the lower tier drug.

Note: If you purchase a Prescription Drug from a Non-Network Pharmacy, you are responsible for any difference between what the Non-Network Pharmacy charges and the amount we would have paid for the same Prescription Drug dispensed by a Network Pharmacy.

SFXRPTTT07PA

Other Important Information about your Outpatient Prescription Drug Benefits

You are responsible for paying the lower of the applicable Copayment and/or Coinsurance or the retail Network Pharmacy's Usual and Customary Charge, or the lower of the applicable Copayment and/or Coinsurance or the mail order Network Pharmacy's Prescription Drug Cost.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug up to the stated supply limit. Some Prescription Drugs are subject to additional supply limits

Some Prescription Drug or Pharmaceutical Products for which Benefits are described under the Prescription Drug section of the Summary Plan Description (SPD) are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Product(s) first.

Also note that some Prescription Drugs require that you obtain prior authorization from us in advance to determine whether the Prescription Drug meets the definition of a Covered Health Service and is not Experimental, Investigational or Unproven.

You may be required to fill an initial Prescription Drug Product order and obtain on refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Pharmacy Exclusions

Exclusions from coverage listed in the SPD apply also to this Prescription Drug section. In addition, the following exclusions apply:

Exclusions

- Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drugs dispensed outside the United States, except as required for Emergency treatment.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined to be experimental, investigational or unproven, unless United HealthCare Services, Inc. and the Florida Municipal Insurance Trust have agreed to cover.
- Prescription Drugs furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Prescription Drugs for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- A Pharmaceutical Product for which Benefits are provided in the Summary Plan Description (SPD). This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
- Unit dose packaging of Prescription Drugs.
- Medications used for cosmetic purposes.
- Prescription Drugs, including New Prescription Drugs or new dosage forms, that Florida Municipal Insurance Trust determine do not meet the definition of a Covered Health Service.
- Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- Prescription Drugs when prescribed to treat infertility.
- Certain Prescription Drugs for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Plan Administrator has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.
- Certain New Prescription Drugs and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- A Prescription Drug that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug.
- A Prescription Drug that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug.

-
- A Prescription Drug typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo provera and other injectable drugs used for contraception.
 - Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

(0162) Emerald Coast Utilities Authority**January 2015**

MEDICAL	277,660.00		
RX	101,143.00		
TOTAL	378,803.00	494,508.74	76.60%

February 2015

MEDICAL	235,612.00		
RX	128,742.00		
TOTAL	364,354.00	505,961.28	72.01%

March 2015

MEDICAL	429,601.00		
RX	100,414.00		
TOTAL	530,015.00	520,501.22	101.83%

April 2015

MEDICAL	325,948.00		
RX	112,796.00		
TOTAL	438,744.00	528,384.34	83.04%

May 2015

MEDICAL	308,637.00		
RX	84,641.00		
TOTAL	393,278.00	528,925.38	74.35%

June 2015

MEDICAL	471,818.00		
RX	102,092.00		
TOTAL	573,910.00	519,642.18	110.44%

July 2015

MEDICAL	471,461.00		
RX	81,167.00		
TOTAL	552,628.00	516,424.70	107.01%

August 2015

MEDICAL	434,527.00		
RX	91,805.00		
TOTAL	526,332.00	528,567.72	99.58%

September 2015

MEDICAL	306,508.00		
RX	85,008.00		
TOTAL	391,516.00	529,004.98	74.01%

October 2015

MEDICAL	244,048.00		
RX	93,114.00		
TOTAL	337,162.00	591,356.87	57.01%

November 2015

MEDICAL	493,217.00		
RX	101,797.00		
TOTAL	595,014.00	589,723.08	100.90%

December 2015

CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
MEDICAL	346,770.00		
RX	100,996.00		
TOTAL	447,766.00	599,651.75	74.67%

GROUP TOTALS	MEDICAL	PAID AMT	PREMIUM	LOSS RATIO
	MEDICAL	4,345,807.00		
	RX	1,183,715.00		
	TOTAL	5,529,522.00	6,452,652.24	85.69%

(0162) Emerald Coast Utilities Authority**January 2015**

MEDICAL	2.00		
RX	0.00		
TOTAL	2.00	0.00	0.00%

April 2015

MEDICAL	95.00		
RX	0.00		
TOTAL	95.00	0.00	0.00%

May 2015

MEDICAL	-383.00		
RX	0.00		
TOTAL	-383.00	0.00	0.00%

June 2015

MEDICAL	33.00		
RX	0.00		
TOTAL	33.00	0.00	0.00%

July 2015

MEDICAL	6.00		
RX	0.00		
TOTAL	6.00	0.00	0.00%

December 2015

MEDICAL	-85.00		
RX	0.00		
TOTAL	-85.00	0.00	0.00%

PLAN TOTALS	MEDICAL	-332.00		
	RX	0.00		
	TOTAL	-332.00	0.00	0.00%

Med Supp Plan**January 2015**

MEDICAL	374.00		
RX	10,664.00		
TOTAL	11,038.00	6,120.00	180.36%

February 2015

MEDICAL	1,105.00		
RX	7,626.00		
TOTAL	8,731.00	6,120.00	142.66%

March 2015

MEDICAL	2,499.00		
RX	5,489.00		
TOTAL	7,988.00	4,871.88	163.96%

April 2015

--	--	--	--

MEDICAL	2,464.00		
RX	4,379.00		
TOTAL	6,843.00	6,120.00	111.81%

May 2015

MEDICAL	686.00		
RX	4,777.00		
TOTAL	5,463.00	6,120.00	89.26%

June 2015

MEDICAL	945.00		
RX	6,820.00		
TOTAL	7,765.00	6,120.00	126.88%

July 2015

MEDICAL	2,516.00		
RX	10,227.00		
TOTAL	12,743.00	4,896.00	260.27%

August 2015

MEDICAL	1,243.00		
RX	9,312.00		
TOTAL	10,555.00	5,712.00	184.79%

September 2015

MEDICAL	1,777.00		
RX	9,625.00		
TOTAL	11,402.00	6,120.00	186.31%

October 2015

MEDICAL	803.00		
RX	6,568.00		
TOTAL	7,371.00	0.00	0.00%

November 2015

MEDICAL	260.00		
RX	0.00		
TOTAL	260.00	0.00	0.00%

December 2015

MEDICAL	74.00		
RX	0.00		
TOTAL	74.00	0.00	0.00%

PLAN TOTALS	MEDICAL	14,746.00		
	RX	75,487.00		
	TOTAL	90,233.00	52,199.88	172.86%

Plan 14

January 2015

MEDICAL	211,659.00		
RX	60,833.00		
TOTAL	272,492.00	363,912.74	73.27%

February 2015

CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
MEDICAL	188,208.00		
RX	99,899.00		
TOTAL	288,107.00	365,722.60	78.78%
March 2015			
MEDICAL	364,292.00		
RX	77,012.00		
TOTAL	441,304.00	382,256.02	112.96%
April 2015			
MEDICAL	256,459.00		
RX	88,890.00		
TOTAL	345,349.00	383,881.78	88.29%
May 2015			
MEDICAL	241,746.00		
RX	50,193.00		
TOTAL	291,939.00	383,975.50	73.65%
June 2015			
MEDICAL	391,743.00		
RX	59,339.00		
TOTAL	451,082.00	377,703.86	119.56%
July 2015			
MEDICAL	376,714.00		
RX	52,499.00		
TOTAL	429,213.00	376,455.78	113.01%
August 2015			
MEDICAL	308,912.00		
RX	63,043.00		
TOTAL	371,955.00	380,952.66	95.87%
September 2015			
MEDICAL	244,627.00		
RX	63,710.00		
TOTAL	308,337.00	383,757.02	80.54%
October 2015			
MEDICAL	115,230.00		
RX	70,421.00		
TOTAL	185,651.00	421,269.33	37.35%
November 2015			
MEDICAL	334,250.00		
RX	74,171.00		
TOTAL	408,421.00	420,408.36	88.07%
December 2015			
MEDICAL	222,530.00		
RX	66,915.00		
TOTAL	289,445.00	418,276.71	68.03%

PLAN TOTALS	CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
	MEDICAL	3,256,370.00		
	RX	826,925.00		
	TOTAL	4,083,295.00	4,658,572.36	87.65%

Plan 4**January 2015**

MEDICAL	2,656.00		
RX	0.00		
TOTAL	2,656.00	0.00	0.00%

February 2015

MEDICAL	338.00		
RX	0.00		
TOTAL	338.00	0.00	0.00%

March 2015

MEDICAL	191.00		
RX	0.00		
TOTAL	191.00	0.00	0.00%

April 2015

MEDICAL	1,717.00		
RX	0.00		
TOTAL	1,717.00	0.00	0.00%

May 2015

MEDICAL	0.00		
RX	-264.00		
TOTAL	-264.00	0.00	0.00%

June 2015

MEDICAL	-11.00		
RX	0.00		
TOTAL	-11.00	0.00	0.00%

July 2015

MEDICAL	-40.00		
RX	0.00		
TOTAL	-40.00	0.00	0.00%

September 2015

MEDICAL	1,350.00		
RX	0.00		
TOTAL	1,350.00	0.00	0.00%

October 2015

MEDICAL	-17.00		
RX	0.00		
TOTAL	-17.00	0.00	0.00%

PLAN TOTALS	MEDICAL	6,184.00		
	RX	-264.00		
	TOTAL	5,920.00	0.00	0.00%

Plan 5**January 2015**

MEDICAL	60,566.00		
RX	29,646.00		
TOTAL	90,212.00	124,476.00	64.57%

February 2015

MEDICAL	44,110.00		
RX	21,217.00		
TOTAL	65,327.00	134,118.68	48.45%

March 2015

MEDICAL	57,994.00		
RX	17,841.00		
TOTAL	75,835.00	133,373.32	55.04%

April 2015

MEDICAL	64,703.00		
RX	17,804.00		
TOTAL	82,507.00	138,382.56	60.41%

May 2015

MEDICAL	66,661.00		
RX	35,893.00		
TOTAL	102,554.00	138,829.88	74.43%

June 2015

MEDICAL	78,260.00		
RX	35,933.00		
TOTAL	114,193.00	135,818.32	80.30%

July 2015

MEDICAL	92,277.00		
RX	18,441.00		
TOTAL	110,718.00	135,072.92	82.67%

August 2015

MEDICAL	124,322.00		
RX	19,440.00		
TOTAL	143,762.00	141,903.06	80.63%

September 2015

MEDICAL	58,380.00		
RX	11,673.00		
TOTAL	70,053.00	139,127.96	49.86%

October 2015

MEDICAL	128,807.00		
RX	16,125.00		
TOTAL	144,932.00	170,087.54	85.89%

November 2015

MEDICAL	158,707.00		
RX	27,626.00		
TOTAL	186,333.00	169,314.72	107.72%

December 2015

MEDICAL	124,405.00		
RX	34,081.00		
TOTAL	158,486.00	181,375.04	85.18%

PLAN TOTALS	MEDICAL	1,059,192.00		
	RX	285,720.00		
	TOTAL	1,344,912.00	1,741,880.00	77.21%

Plan 8 (HDHP)**January 2015**

MEDICAL	225.00		
RX	0.00		
TOTAL	225.00	0.00	0.00%

March 2015

MEDICAL	3,960.00		
RX	19.00		
TOTAL	3,979.00	0.00	0.00%

July 2015

MEDICAL	-12.00		
RX	0.00		
TOTAL	-12.00	0.00	0.00%

August 2015

MEDICAL	0.00		
RX	10.00		
TOTAL	10.00	0.00	0.00%

PLAN TOTALS	MEDICAL	4,173.00		
	RX	29.00		
	TOTAL	4,202.00	0.00	0.00%

Plan 9**January 2015**

MEDICAL	2,178.00		
RX	0.00		
TOTAL	2,178.00	0.00	0.00%

February 2015

MEDICAL	1,851.00		
RX	0.00		
TOTAL	1,851.00	0.00	0.00%

March 2015

--	--	--	--

MEDICAL	665.00		
RX	53.00		
TOTAL	718.00	0.00	0.00%

April 2015

MEDICAL	510.00		
RX	1,723.00		
TOTAL	2,233.00	0.00	0.00%

May 2015

MEDICAL	-73.00		
RX	-5,958.00		
TOTAL	-6,031.00	0.00	0.00%

June 2015

MEDICAL	848.00		
RX	0.00		
TOTAL	848.00	0.00	0.00%

August 2015

MEDICAL	50.00		
RX	0.00		
TOTAL	50.00	0.00	0.00%

September 2015

MEDICAL	374.00		
RX	0.00		
TOTAL	374.00	0.00	0.00%

October 2015

MEDICAL	-775.00		
RX	0.00		
TOTAL	-775.00	0.00	0.00%

December 2015

MEDICAL	-154.00		
RX	0.00		
TOTAL	-154.00	0.00	0.00%

PLAN TOTALS	MEDICAL	5,474.00		
	RX	-4,182.00		
	TOTAL	1,292.00	0.00	0.00%

GROUP TOTALS	MEDICAL	4,345,807.00		
	RX	1,183,715.00		
	TOTAL	5,529,522.00	6,452,652.24	85.69%

(0162) Emerald Coast Utilities Authority**October 2015**

MEDICAL	244,048.00		
RX	93,114.00		
TOTAL	337,162.00	591,356.87	57.01%

November 2015

MEDICAL	493,217.00		
RX	101,797.00		
TOTAL	595,014.00	589,723.08	100.90%

December 2015

MEDICAL	346,770.00		
RX	100,996.00		
TOTAL	447,766.00	599,651.75	74.67%

GROUP TOTALS

MEDICAL	1,084,035.00		
RX	295,907.00		
TOTAL	1,379,942.00	1,780,731.70	77.49%

ECUA Plan 5 Membership By Month Oct 15-Dec 15

Membership Year/Month	Single Subscribers	plus Spouse	plus Child/Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2015-10	101	20	7	31	159	128	287
2015-11	101	19	7	32	159	129	288
2015-12	102	19	7	34	162	133	295
Total	304	58	21	97	480	390	870

ECUA Plan 14 Membership By Month Oct 15-Dec 15

Membership Year/Month	Single Subscribers	plus Spouse	plus Child/Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2015-10	267	34	30	65	396	294	690
2015-11	270	34	29	65	398	293	691
2015-12	272	34	29	64	399	291	690
Total	809	102	88	194	1,193	878	2,071

LARGE LOSS WITH DIAGNOSIS REPORT

Customer Name **FLORIDA MUNICIPAL INSURANCE TRUST**

Policy Number: 000706662
 Service Dates: ALL
 Paid Dates: 10/01/2015 - 12/31/2015
 Coverage Types: Medical, Mental Health, Substance Abuse, and Managed Pharmacy
 Threshold: \$50,000.00

Claimant ID	Plan Variation	Diagnosis Code	Diagnosis Description	Total Paid
Claimant 2	0450	K750	ABSCESS OF LIVER	\$ 118,305.59
Claimant 11	0449	5409	ACUT APPENDICITIS W/O PERITONITIS	\$ 72,482.94
Claimant 19	0449	Z3801	SINGLE LIVEBORN INFANT DELIV C-SECT	\$ 59,126.44
Claimant 20	0450	K353	ACUTE APPENDICITIS W/LOC PERITONIT	\$ 58,666.29
Claimant 22	0450	I739	PERIPHERAL VASCULAR DISEASE UNS	\$ 52,589.71

UnitedHealthcare's ARRA Statement:

Information included in this document is considered to be UnitedHealthcare's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it was addressed by UnitedHealthcare. Such recipient shall be liable for using and protecting UnitedHealthcare's proprietary business information from further disclosure or misuse, consistent with the recipient's contractual obligations under any applicable administrative services agreement, group policy contract, non-disclosure agreement or other applicable contract or law. The report you have received may contain protected health information (PHI) and must be handled according to applicable state and federal law, including, but not limited to HIPAA. Individuals who misuse this information may be subject to both state and federal law.

Created On 1/22/2016 11:41:09 AM by Kristopher J Hogendorn
 UnitedHealthcare - Underwriting Pricing

Request # 553150

FLORIDA MUNICIPAL INSURANCE TRUST - LARGE LOSS - 553150 - DEC

(0162) Emerald Coast Utilities Authority**October 2014**

MEDICAL	351,863.00		
RX	100,134.00		
TOTAL	451,997.00	491,168.56	92.02%

November 2014

MEDICAL	366,624.00		
RX	83,852.00		
TOTAL	450,476.00	501,288.72	89.86%

December 2014

MEDICAL	309,505.00		
RX	110,021.00		
TOTAL	419,526.00	503,449.42	83.33%

January 2015

MEDICAL	277,660.00		
RX	101,143.00		
TOTAL	378,803.00	494,508.74	76.60%

February 2015

MEDICAL	235,612.00		
RX	128,742.00		
TOTAL	364,354.00	505,961.28	72.01%

March 2015

MEDICAL	429,601.00		
RX	100,414.00		
TOTAL	530,015.00	520,501.22	101.83%

April 2015

MEDICAL	325,948.00		
RX	112,796.00		
TOTAL	438,744.00	528,384.34	83.04%

May 2015

MEDICAL	308,637.00		
RX	84,641.00		
TOTAL	393,278.00	528,925.38	74.35%

June 2015

MEDICAL	471,818.00		
RX	102,092.00		
TOTAL	573,910.00	533,995.34	107.47%

July 2015

MEDICAL	471,461.00		
RX	81,167.00		
TOTAL	552,628.00	535,222.76	103.25%

August 2015

MEDICAL	434,527.00		
RX	91,805.00		
TOTAL	526,332.00	528,567.72	99.58%

September 2015

CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
MEDICAL	306,508.00		
RX	85,008.00		
TOTAL	391,516.00	529,004.98	74.01%

GROUP TOTALS	MEDICAL	4,289,764.00		
	RX	1,181,815.00		
	TOTAL	5,471,579.00	6,200,978.46	88.24%

ECUA Plan 5 Membership By Month Oct 14-Sept 15

Membership Year/Month	Single	Subscribers plus Spouse	plus Child/Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2014-10	81	16	3	27	127	115	242
2014-11	83	16	3	27	129	113	242
2014-12	83	16	3	27	129	113	242
2015-01	86	14	2	28	130	112	242
2015-02	92	15	2	31	140	121	261
2015-03	91	15	3	31	140	123	263
2015-04	93	14	6	31	144	125	269
2015-05	95	14	6	31	146	125	271
2015-06	94	13	6	30	143	122	265
2015-07	94	14	6	30	144	123	267
2015-08	92	15	6	30	143	124	267
2015-09	93	15	6	31	145	127	272
Total	1,077	177	52	354	1,660	1,443	3,103

ECUA Plan 14 Membership By Month Oct 14-Sept 15

Membership Year/Month	Single	Subscribers plus Spouse	plus Child/Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2014-10	264	35	25	61	385	264	649
2014-11	266	36	27	61	390	266	656
2014-12	265	36	27	60	388	264	652
2015-01	269	37	24	60	390	260	650
2015-02	277	37	26	60	400	266	666
2015-03	279	37	27	65	408	287	695
2015-04	274	36	29	66	405	293	698
2015-05	275	37	29	66	407	294	701
2015-06	274	36	28	65	403	289	692
2015-07	275	35	27	66	403	289	692
2015-08	273	35	27	69	404	299	703
2015-09	275	35	27	69	406	299	705
Total	3,266	432	323	768	4,789	3,370	8,159

LARGE LOSS WITH DIAGNOSIS REPORT

Customer Name FLORIDA MUNICIPAL INSURANCE TRUST

Policy Number: 000706662
 Service Dates: 10/01/2014 - 09/30/2015
 Paid Dates: 10/01/2014 - 09/30/2015
 Coverage Types: Medical, Mental Health, Substance Abuse, and Managed Pharmacy
 Threshold: \$50,000.00
 PVRC Filter: 0449;0450;0451;0452;0453;0454;0455

Claimant ID	Diagnosis Code	Diagnosis Description	Total Paid
Claimant 1	25041	DB W/RENAL TYPE I [JUV] NOT UNCNTL	\$ 227,377.59
Claimant 2	42731	ATRIAL FIBRILLATION	\$ 201,764.26
Claimant 3	5856	END STAGE RENAL DISEASE	\$ 181,389.98
Claimant 4	V5811	ENCOUNTER ANTINEOPLASTIC CHEMO	\$ 166,385.51
Claimant 5	5990	UTI SITE NOT SPECIFIED	\$ 154,715.19
Claimant 6	1529	MALIG NEOPLSM SM INTEST UNSPEC SITE	\$ 129,293.20
Claimant 7	5856	END STAGE RENAL DISEASE	\$ 120,688.51
Claimant 8	V580	RADIOTHERAPY	\$ 114,962.05
Claimant 9	1890	MALIG NEOPLASM KIDNEY EXCEPT PELVIS	\$ 111,199.25
Claimant 10	7054	CHRONIC HEP C W/O MENTION HEP COMA	\$ 100,204.79
Claimant 11	V5811	ENCOUNTER ANTINEOPLASTIC CHEMO	\$ 97,131.01
Claimant 12	V5811	ENCOUNTER ANTINEOPLASTIC CHEMO	\$ 94,724.78
Claimant 13	7140	RHEUMATOID ARTHRITIS	\$ 81,471.21
Claimant 14	42731	ATRIAL FIBRILLATION	\$ 81,148.19
Claimant 15	99831	DISRUPT INTERN OPERTION SURG WOUND	\$ 65,082.34
Claimant 16	99999	OTHER DIAGNOSES	\$ 64,424.45
Claimant 17	25050	DB W/OPHTH TYPE II/UNS NOT UNCNTL	\$ 54,697.53
Claimant 18	185	MALIGNANT NEOPLASM OF PROSTATE	\$ 51,885.00
Claimant 19	71536	LOC OSTEOARTHROSIS-LOWER LEG	\$ 51,053.58
Claimant 20	4241	AORTIC VALVE DISORDERS	\$ 50,578.53

UnitedHealthcare's ARRA Statement:

Information included in this document is considered to be UnitedHealthcare's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it was addressed by UnitedHealthcare. Such recipient shall be liable for using and protecting UnitedHealthcare's proprietary business information from further disclosure or misuse, consistent with the recipient's contractual obligations under any applicable administrative services agreement, group policy contract, non-disclosure agreement or other applicable contract or law. The report you have received may contain protected health information (PHI) and must be handled according to applicable state and federal law, including, but not limited to HIPAA. Individuals who misuse this information may be subject to both civil and criminal penalties.

Created On 2/3/2016 12:10:00 PM by mmonro4
 UnitedHealthcare - Underwriting Pricing
 Request # 580247

FLORIDA MUNICIPAL INSURANCE TRUST - LARGE LOSS - 580247

(0162) Emerald Coast Utilities Authority**October 2013**

MEDICAL	58,363.00		
RX	21,961.00		
TOTAL	80,324.00	455,347.56	17.64%

November 2013

MEDICAL	271,170.00		
RX	56,853.00		
TOTAL	328,023.00	472,461.68	69.43%

December 2013

MEDICAL	372,855.00		
RX	59,763.00		
TOTAL	432,618.00	458,325.08	94.39%

January 2014

MEDICAL	271,393.00		
RX	66,563.00		
TOTAL	337,956.00	456,606.34	74.01%

February 2014

MEDICAL	243,553.00		
RX	63,098.00		
TOTAL	306,651.00	452,607.94	67.75%

March 2014

MEDICAL	411,310.00		
RX	56,232.00		
TOTAL	467,542.00	453,506.88	103.09%

April 2014

MEDICAL	239,390.00		
RX	72,504.00		
TOTAL	311,894.00	456,589.56	68.31%

May 2014

MEDICAL	439,542.00		
RX	101,241.00		
TOTAL	540,783.00	462,028.46	117.05%

June 2014

MEDICAL	372,619.00		
RX	81,857.00		
TOTAL	454,476.00	451,676.07	100.62%

July 2014

MEDICAL	358,096.00		
RX	97,556.00		
TOTAL	455,652.00	452,236.78	100.76%

August 2014

MEDICAL	449,685.00		
RX	99,388.00		
TOTAL	549,073.00	455,088.62	120.65%

September 2014

CLAIM TYPE	PAID AMT	PREMIUM	LOSS RATIO
MEDICAL	386,439.00		
RX	105,748.00		
TOTAL	492,187.00	458,538.64	107.34%

GROUP TOTALS	MEDICAL	3,874,415.00		
	RX	882,764.00		
	TOTAL	4,757,179.00	5,485,013.61	86.73%

ECUA Plan 4 Membership By Month Oct 13-Sept 14

Membership Year/Month	Single Subscribers	plus Spouse	plus Child/Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2013-10	282	10	4	12	308	50	358
2013-11	286	10	4	11	311	50	361
2013-12	286	9	3	12	310	51	361
2014-01	284	8	3	12	307	50	357
2014-02	288	8	3	12	311	50	361
2014-03	285	8	3	12	308	49	357
2014-04	286	7	3	12	308	49	357
2014-05	287	7	3	11	308	47	355
2014-06	284	6	3	11	304	46	350
2014-07	289	5	3	11	308	45	353
2014-08	287	5	3	11	306	45	351
2014-09	290	5	3	12	310	48	358
Total	3,434	88	38	139	3,699	580	4,279

ECUA Plan 8 Membership By Month Oct 13-Sept 14

Membership Year/Month	Single Subscribers	plus Spouse	plus Child/Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2013-10	46	10	1	18	75	76	151
2013-11	46	10	1	18	75	76	151
2013-12	45	10	1	18	74	76	150
2014-01	45	10	1	18	74	76	150
2014-02	45	10	1	18	74	76	150
2014-03	44	10	1	17	72	71	143
2014-04	43	12	1	17	73	73	146
2014-05	43	12	1	17	73	73	146
2014-06	40	12	1	17	70	73	143
2014-07	40	12	1	17	70	73	143
2014-08	40	12	1	17	70	73	143
2014-09	40	12	1	18	71	76	147
Total	517	132	12	210	871	892	1,763

ECUA Plan 9 Membership By Month Oct 13-Sept 14

Membership Year/Month	Single Subscribers	plus Spouse	plus Child/Children	plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
2013-10	17	37	20	54	128	250	378
2013-11	20	35	21	54	130	248	378
2013-12	20	35	22	53	130	245	375
2014-01	21	35	21	54	131	245	376
2014-02	20	36	19	54	129	244	373
2014-03	19	36	19	54	128	245	373
2014-04	19	36	20	54	129	245	374
2014-05	19	36	21	57	133	255	388
2014-06	19	36	20	58	133	254	387
2014-07	18	32	21	57	128	247	375
2014-08	18	32	22	58	130	251	381
2014-09	18	31	22	58	129	250	379
Total	228	417	248	665	1,558	2,979	4,537

LARGE LOSS WITH DIAGNOSIS REPORT

Customer Name **FLORIDA MUNICIPAL INSURANCE TRUST**

 Policy Number: 000706662
 Service Dates: 10/01/2013 - 09/30/2014
 Paid Dates: 10/01/2013 - 09/30/2014
 Coverage Types: Medical, Mental Health, Substance Abuse, and Managed Pharmacy
 Threshold: \$50,000.00
 Filtered by: PVRC '0356', '0357', '0358', '0359', '0360', '0361', '0362', '0363', '0364',

Claimant ID	Diagnosis Code	Diagnosis Description	Total Paid
Claimant 1	4466	THROMBOTIC MICROANGIOPATHY	\$ 239,768.15
Claimant 2	5856	END STAGE RENAL DISEASE	\$ 202,155.18
Claimant 3	4241	AORTIC VALVE DISORDERS	\$ 144,271.20
Claimant 4	25080	DB W/OTH MANIFST TYPE II/UNS NOT UN	\$ 135,582.29
Claimant 5	5856	END STAGE RENAL DISEASE	\$ 117,955.59
Claimant 6	389	UNSPECIFIED SEPTICEMIA	\$ 115,574.40
Claimant 7	V5811	ENCOUNTER ANTINEOPLASTIC CHEMO	\$ 110,032.67
Claimant 8	3484	COMPRESSION OF BRAIN	\$ 106,284.38
Claimant 9	41071	ACUT MI SUBNDOCRDL INFARCT INIT EOC	\$ 77,140.77
Claimant 10	45341	AC VNUS EMB&THRMB DP VES PRX LW EXT	\$ 74,123.87
Claimant 11	25050	DB W/OPHTH TYPE II/UNS NOT UNCNTL	\$ 70,102.30
Claimant 12	43491	UNSPEC CERBRL ART OCCL W/INFARCT	\$ 61,483.83
Claimant 13	72252	DEGEN LUMB/LUMBOSAC INTERVERT DISC	\$ 58,760.56
Claimant 14	8244	CLOSED BIMALLEOLAR FRACTURE	\$ 56,762.19
Claimant 15	5070	PNEUMONITIS DUE INHAL FOOD/VOMITUS	\$ 56,633.92

UnitedHealthcare's ARRA Statement:

Information included in this document is considered to be UnitedHealthcare's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it was addressed by UnitedHealthcare. Such recipient shall be liable for using and protecting UnitedHealthcare's proprietary business information from further disclosure or misuse, consistent with the recipient's contractual obligations under any applicable administrative services agreement, group policy contract, non-disclosure agreement or other applicable contract or law. The report you have received may contain protected health information (PHI) and must be handled according to applicable state and federal law, including, but not limited to HIPAA. Individuals who misuse this information may be subject to both civil and criminal penalties.

Created On 2/5/2016 7:55:54 AM by Md B Islam
 UnitedHealthcare - Underwriting Pricing
 Request # 580236
 FLORIDA MUNICIPAL INSURANCE TRUST - LARGE LOSS - 580236