SCHEDULE OF MEDICAL BENEFITS – 2011

Medical Plan Features	Standard PPO For NETWORK providers the Plan pays . . .	Standard PPO For NON-NETWORK providers the Plan pays . . .	Consumer Driven HSA For NETWORK providers the Plan pays . . .	Consumer Driven HSA For NON-NETWORK providers the Plan pays . . .
NurseLine: Pin 185 1-888-609-5880	A Nurse is available to provide immediate medical info & support 24 hrs/day; 100% covered.			
Preventive Care Routine physical Immunization Pap test Mammogram	100% after $20 copay/office visit up to $300/person max/cal yr (deductible does not apply)	Not covered	100% after $25 copay/office visit up to $300/person max/cal yr (deductible does not apply)	Not covered
Well Baby Care	100% after $20 copay/office visit up to 2nd birthday (deductible does not apply)	Not covered	Covered under Preventive Care	Not covered
Chiropractic	$30 copay Limit 6 visits/cal year (deductible does not apply)	50% of MNRP[1] Limit 6 visits/cal year (deductible applies)	80% Limit 6 visits/cal year (deductible applies)	60% of MNRP[1] Limit 6 visits/cal year (deductible applies)
Physician Services Office Visits	100% after $20 copay/ office visit $30 copay/ specialist visit (deductible does not apply)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
Hospital Services Hospital Visits Inpatient Surgery Outpatient Surgery Hospital Newborn Care	80% hospital visits and surgery (deductible applies)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
Health Care Facility Hospital Outpatient (minor surgery, radiation therapy) Hospital Inpatient[2] (room and board, x-rays, intensive care, newborn routine nursery care) Skilled Nursing Facility[2] (room & board up to semiprivate room rate, up to 120 days/cal year) Home Health Care[2] (up to 130 visits/cal year) Hospice Care[2] (up to $5,000 max)	80% (deductible applies)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)

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X-Ray and Lab **Anesthesiology**	80% (deductible applies)	80% when ordered by a network provider (deductible applies) 50% of MNRP[1] when ordered by a non-network provider (deductible applies)	80% (deductible applies)	80% when ordered by a network provider (deductible applies) 60% of MNRP[1] when ordered by a non-network provider (deductible applies)
Hospital Emergency Room	80% after $75 copay for emergencies (deductible does not apply) (copayment is not waived even if admitted) 80% after $125 copay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	80% of MNRP[1] after $75 copay for emergencies (deductible does not apply) (copayment is not waived even if admitted) 50% of MNRP[1] after $125 copay for non-emergencies (deductible applies) (copayment is not waived even if admitted)	80% for emergencies (deductible applies) 60% for non-emergencies (deductible applies)	80% of MNRP[1] for emergencies (deductible applies) 60% of MNRP[1] for non-emergencies (deductible applies)
Urgent Care Centers	100% after $30 copayment/visit (deductible does not apply)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
Other Covered Health Services: Ambulance Service Durable Medical Equipment	80% (deductible applies)	80% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
Rehabilitation Therapy: Physical, Speech, Occupational and Respiratory therapy Infertility Treatment (maximums apply; see Covered Health services –Infertility section)	80% (deductible applies)	50% of MNRP[1] (deductible applies)	80% (deductible applies)	60% of MNRP[1] (deductible applies)
Bariatric Surgery[2]	80% (deductible applies) (does not count against the out-of-pocket maximum)	50% of MNRP[1] (deductible applies) (does not count against the out-of-pocket maximum)	80% (deductible applies) (does not count against the out-of-pocket maximum)	60% of MNRP[1] (deductible applies) (does not count against the out-of-pocket maximum)

Medical Plan Features	Standard PPO For NETWORK providers the Plan pays . . .	Standard PPO For NON-NETWORK providers the Plan pays . . .	Consumer Driven HSA For NETWORK providers the Plan pays . . .	Consumer Driven HSA For NON-NETWORK providers the Plan pays . . .
Outpatient Prescription Drugs Tiers as determined by the United HealthCare Prescription Drug List (PDL). See www.myuhc.com for the most current list.	Tier 1 - 90% ($10 min/$20 max) Tier 2 - 80% ($25 min/$45 max) Tier 3 - 60% ($50 min/$70 max) **Mail Order** (90-day supply) Tier 1 - 90% ($20 min/$40 max) Tier 2 - 80% ($50 min/$90 max) Tier 3 - 60% ($100 min/$140 max) (deductible/out-of-pocket maximums do not apply)	Not covered	Tier 1- 80% ($20 min/$40 max) Tier 2 - 60% ($40 min/$60 max) Tier 3 - 50% ($60 min/$80 max) **Mail Order** (90-day supply) Tier 1 - 80% ($40 min/$80 max) Tier 2 - 60% ($80 min/$120 max) Tier 3 - 50% ($120 min/$160 max) (deductibles/out-of-pocket maximums apply)	Not covered
Mental Health and Substance Abuse[3]				
Inpatient Care[3] (maximums apply; see Mental Health and Substance Abuse section)	80% (deductible applies / out-of-pocket maximums do not apply)	50% of MNRP[1] (deductible applies / out-of-pocket maximums do not apply)	80% (deductible applies / out-of-pocket maximums do not apply)	60% of MNRP[1] (deductible applies / out-of-pocket maximums do not apply)
Outpatient Care[3] (maximums apply; see Mental Health and Substance Abuse section)	80%, after $20 copayment (deductible / out-of-pocket maximums do not apply)	50% of MNRP[1] (deductible / out-of-pocket maximums do not apply)	80% (deductible applies/ out-of-pocket maximums do not apply)	60% of MNRP[1] (deductible applies/ out-of-pocket maximums do not apply)
Intermediate Care[3]	80% (deductible applies/out-of-pocket maximums do not apply)	50% of MNRP[1] (deductible applies/ out-of-pocket maximums do not apply)	80% (deductible applies/ out-of-pocket maximums do not apply)	60% of MNRP[1] (deductible applies/ out-of-pocket maximums do not apply)
Annual Deductible	$600/person; $1,200/family (applies except where specified)	$1,000/person; $2,000/family (applies except where specified)	$1,250 individual plan; $2,500 total for family plan	$2,500 individual plan; $5,000 total for family plan
Out-Of-Pocket Maximum	$2,500/person; $5,000/family (except where specified)	$5,000/person; $10,000/family (except where specified)	$3,500/person; $7,000/family	$5,000/person; $10,000/family
Non-Notification Penalty	$200 penalty applies to health facility services requiring pre-notification with UHC $200 penalty applies to Mental Health/Substance Abuse services requiring UBH pre-notification			
Maximum Lifetime Benefit	NONE			

[1] Maximum Non-Network Reimbursement Program [2] Pre-notification with UHC is required to receive full plan benefit and avoid penalty [3] Pre-notification with UBH is required to receive full plan benefits and avoid penalty.
NOTE: Copayments do not apply towards deductible or out-of-pocket maximum.

Go to www.myUHC.com to review your claims, check eligibility of your dependents, order an ID card, locate network providers, and research information on many health topics.