

2012 Benefit Summary Matrix for Conversion Copayment 25 Plan
UnitedHealthcare of California

This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefit summary is available on the plan's or insurer's site.

Plan Name UnitedHealthcare of California	Plan Contact Name and Phone Number Member Service Call Center (800) 624-8822 or (800) 442-8833 (TDHI)
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Coverage summary

Eligibility requirements	An employee or member whose coverage under a group contract has been terminated by an employer is eligible for individual conversion coverage. Such coverage is not required to be offered under the circumstances (*1).
The premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside	Premiums charged by plans vary by region and age of subscribers. See "Premium Rate" tab for this plan.
When and under what circumstances benefits cease	Member no longer meets the Eligibility Requirements in the Conversion Subscriber Agreement (*****6) Nonpayment of Health Plan premiums or partial payment of premiums after a written notice of at least a 30-day grace period Member fraud or intentional misrepresentation of a material fact Voluntary disenrollment by Subscriber, in writing Withdrawal of the benefit plan from the Individual market Discontinuance of a product
The terms under which coverage may be renewed	New sales are issued throughout the calendar year. All accounts renew annually.
The circumstances under which choice in the selection of physicians and providers is permitted	Members are encouraged to choose a primary care physician from a list of available Plan physicians in the following specialties: internal medicine, obstetrics/gynecology, family medicine and pediatrics. Members may change their primary care physician at any time.
Lifetime and annual maximums	No lifetime maximum. Annual copay maximums are \$2,500 per individual, no family maximum. Annual copayment maximum does not include copayments for supplemental outpatient prescription drug benefits or durable medical equipment.
Deductibles	None

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Benefits Summary (**2) & (**3)		Co-payments	Limitation
Professional Services	Most primary and specialty care consultations, exams, and treatment	\$25 per visit	
	Routine physical maintenance exams	No charge	
	Well-child preventive care exams (through age 23 months)	No charge	
	Family planning counseling	No charge	
	Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge	
	Eye exams for refraction	No charge	
	Hearing exams	No charge	
	Urgent care consultations, exams, and treatment	\$25 per visit	
	Physical, occupational, and speech therapy	\$25 per visit	
Outpatient Services	Outpatient surgery and certain other outpatient procedures	\$100 per procedure	
	Allergy injections (including allergy serum)	\$5 per visit	
	Most immunizations (including vaccines)	No charge	
	Most X-rays and laboratory tests	\$10 per encounter	
	Preventive X-rays, screenings, and laboratory tests as described in the "Benefits and Cost Sharing" section	No charge	
	MRI, most CT, and PET scans	\$50 per encounter	
	Health education		
	Covered individual health education counseling and programs	No charge	
	Covered group health education programs	No charge	
Hospitalization Services	Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	\$200 per day	This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing in the "Benefits and Cost Sharing" section of the
Emergency Health Coverage	Emergency Department visits	\$100 per visit	

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Benefits Summary (**2) & (**3)		Co-payments	Limitation
			Evidence of Coverage)
Ambulance Services	Ambulance services	\$100 per trip	
Prescription Drug Coverage	Covered outpatient items in accord with our drug formulary guidelines:		
	Most generic items at a Plan Pharmacy	\$10 for up to a 30-day supply, \$20 for a 31- to 60-day supply, or \$30 for a 61- to 100-day supply	
	Most generic refills through our mail-order service	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply	
	Most brand-name items at a Plan Pharmacy	\$35 for up to a 30-day supply, \$70 for a 31- to 60-day supply, or \$105 for a 61- to 100-day supply	
Durable Medical Equipment	The durable medical equipment for home use listed in the “Benefits and Cost Sharing” section in accord with our durable medical equipment formulary guidelines (most durable medical equipment is not covered)	20% Coinsurance	

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Benefits Summary (**2) & (**3)		Co-payments	Limitation
Mental Health Services	Inpatient psychiatric hospitalization (up to 30 days per calendar year)	\$200 per day	Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the "Benefits and Cost Sharing" section of the Evidence of Coverage
	Outpatient mental health services evaluation and treatment:		
	Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation treatment	\$25 per individual visit \$12 per group visit	
	Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	\$12 per visit	
Residential Treatment	Transitional residential recovery Services	\$100 per admission	Up to 60 days per calendar year, not to exceed 120 days in any five-year period)
Chemical Dependency Services	Inpatient detoxification	\$200 per day	
	Individual outpatient chemical dependency evaluation and treatment	\$25 per visit	
	Group outpatient chemical dependency treatment	\$5 per visit	
Home Health Services	Home health care	No charge	Part-time or intermittent home health covered up to: <ul style="list-style-type: none"> Up to 2 hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist and up to 4 hours per visit for visits by a home health aide Up to 3 visits per day Up to 100 visits per calendar year
Custodial Care and Skilled Nursing Facilities	Skilled Nursing Facility care	No charge	Up to 100 days per benefit period
	Custodial care	Not covered	
Other	The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the "Benefits and Cost Sharing" section (most external prosthetic and orthotic devices are not covered)	No charge	
	Hospice care (**4)	No charge	

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- (*1) (a) The group contract terminated or an employer's participation terminated and the group contract is replaced by similar coverage under another group contract within 15 days of the date of termination of the group coverage or the subscriber's participation.
- (b) The employee or member failed to pay amounts due to the health care service plan.
- (c) The employee or member was terminated by the health care service plan as set forth in the EOC. Please refer to the EOC for details.
- (d) The employee or member knowingly furnished incorrect information or otherwise improperly obtained the benefits of the plan.
- (e) The employer's hospital, medical, or surgical expense benefit program is self-insured.
- (f) For the initial enrollment, you cannot be eligible for or covered under Title XVIII of the United States Social Security Act. If you later become eligible for such coverage, you may continue the Conversion plan coverage.
- (g) The person is covered by or is eligible for hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured.
- (h) The person is covered for similar benefits by an individual policy or contract.
- (i) The person has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

(**2) This is a benefit summary. Please consult the individual plan's Evidence of Coverage for more detailed information on benefits under the plan, including any related exclusions not contained in this benefit summary.

(***3) Percentage copayments represent a percentage of actual cost. When participating providers are compensated on a fee-for-service basis, the actual cost is the negotiated fee rate. In a PPO, percentage copayments for non-emergency services provided by non-participating providers are a percentage of usual, customary or reasonable rates or billed charges, whichever is less, and enrollees are also responsible for any excess amount.

(****4) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.

(****5) Preventive tests/screening/counseling as recommended by the U.S. Preventive Services Task Force and AAP (Bright Futures Recommendations for pediatric preventive health care) will be covered as Paid in Full. There may be a separate copayment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card.

(*****6) Once enrolled in Conversion plan, an enrollee who subsequently becomes eligible for Medicare does not lose his/her eligibility to remain enrolled in Conversion Plan coverage.