Heluna Health®
EMPOWERING POPULATION HEALTH INITIATIVES SINCE 1969

Comprehensive Medical Coverage is an Important Part of Supporting Healthy Living

Heluna Health offers **five** medical plan options, all of which provide **preventive care services at no cost to you** to prevent healthcare problems before they arise. These are comprehensive medical plans to help you cover the costs when you are ill as well as to protect you from any catastrophic financial effects of a serious illness or injury.

You can choose from 3 HMO (Health Maintenance Organization) and 2 PPO (Preferred Provider Organization) plans. The medical plans are different in how they are designed. You decide which plan best meets your needs.

CA EMPLOYEES ONLY

UnitedHealthcare Harmony/Alliance HMO

UnitedHealthcare SignatureValue HMO

Kaiser HMO

CA & NON-CA EMPLOYEES

UnitedHealthcare PPO

UnitedHealthcare HDHP/HSA PPO

UnitedHealthcare AG-RO/PPO (Hawaii)

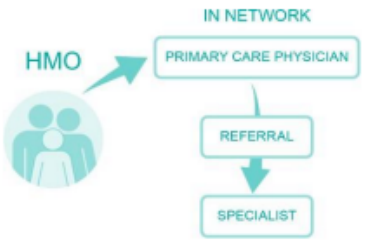
Transition of Care (TOC)

Transition of Care gives new UnitedHealthcare members the option to request extended coverage from their current, out-of-network health care professional at network rates for a limited time due to a specific medical condition until the safe transfer to a network health care professional can be arranged. You must apply for TOC no later than 30 days after the date your coverage begins. The TOC application can be located in UKG.

MEDICAL HMO OVERVIEW

HOW DO HMO PLANS WORK?

At the time of enrollment, you must select a primary care physician (PCP) and medical group. Your care is managed by the medical group and the assigned PCP. Your PCP will refer you to a specialist when it is needed and request pre-authorization for any medically necessary procedures. Most services are covered at 100% after you pay a copayment.



CAN I SELECT DIFFERENT PCPS FOR MYSELF AND MY DEPENDENTS?

Yes, you can select a different PCP for yourself and each of your dependents.

WHAT IF I NEED TO SEE A SPECIALIST?

When you want to see a specialist, like an orthopedic doctor or a cardiologist, you will need to visit your PCP first to get a referral. Your PCP will refer you to a specialist when it is needed and request pre-authorization for any medically necessary procedures.

WHEN CAN I CHANGE MY PCP OR MEDICAL GROUP?

You can change your PCP as often as you wish (even monthly); however, you must contact your plan carrier prior to the 15th of the month for a new provider to be assigned the 1st of the following month.

KAISER HMO PLAN

When enrolled in the Kaiser HMO plan, the physician, hospital, and pharmacy are contracted exclusively with Kaiser. Unlike a standard HMO plan which assigns you to a specific doctor and/or hospital, with Kaiser you are able to seek services with any Kaiser doctor and/or hospital at any time.

Urgent Care centers are contracted with your assigned Medical Group. To locate the nearest contracted Urgent Care center, you must visit the assigned Medical Group's website instead of UHC's provider search site.

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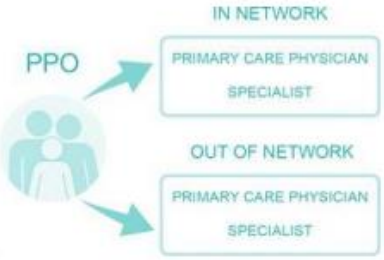
MEDICAL PPO OVERVIEW

HOW DO PPO PLANS WORK?

The PPO allows the member to self-refer to any provider. As a member, you can access care through an in-network (contracted) provider or through an out-of-network (non-contracted provider). You do not need to select a provider at the time of enrollment. However, you should always verify if your provider is contracted with UHC network prior to accessing care.



HIGH DEDUCTIBLE HEALTH PLAN (HDHP)/HEALTH SAVINGS ACCOUNT (HSA) PLAN

A HDHP plan is meant to give you more flexibility and control over your healthcare spending. It allows you to create a plan that meets your family's needs and comes with many of the same benefits as a traditional PPO plan. While your deductible will be higher, your premium will be lower. You can choose to contribute the difference in premium savings into a Health Savings Account. HSAs are like "medical" IRAs. It's a tax-deferred, private savings account designed to pay for certain current and future healthcare expenses with tax-free money. Because they are tax-advantaged and balances can accumulate over time, HSAs can also be used to accumulate savings.

WHAT IS THE DIFFERENCE BETWEEN IN-NETWORK VS OUT-OF-NETWORK PROVIDERS?

PPO plans offer a larger network of providers who have agreed to discount their fees for their services. You may choose to have your treatment provided by a PPO provider (in-network) and receive a higher level of benefit with a lower out-of-pocket cost to you. You may also choose to go outside the network; however, generally, benefits are reimbursed at a lower level and you may have higher out-of-pocket costs.

WHAT HAPPENS IF I RECEIVE CARE THROUGH OUT-OF-NETWORK PROVIDERS?

Using an out-of-network doctor, hospital, or other health care provider can significantly increase your out-of-pocket medical costs. That's because when a member sees an out-of-network provider, the member is responsible for the difference between what the provider charges and the amount UHC pays the provider. UHC uses established rates to pay for medical services for out-of-network doctors, hospitals, and other health care providers. However, out-of-network providers' actual charges are often much higher than UHC established rates, and they may charge members for the difference. This is called balance billing. When a member sees an in-network provider, they won't receive any additional charges from the provider.

EXAMPLE OF A MEMBER'S OFFICE VISIT WITH A SPECIALIST:

Cindy injured her knee and required a consultation with an orthopedic doctor. Cindy has a PPO plan, which gives her the option to seek services from a doctor in the **UHC** provider network, or one who does not participate in the network. The orthopedic doctor Cindy chose charges $450 for the consultation visit. If the doctor is in the **UHC** network, the plan would pay a negotiated rate for Cindy's visit. If the doctor is not in the network, the plan would pay the established rate for the out-of-network office visit. The chart shows how Cindy's out-of-pocket (OOP) costs will be lower if she chooses an in-network doctor.

	IN-NETWORK	OUT-OF-NETWORK
Provider's Actual Charge	$450	$450
UHC Pays	Provider Contracted Rate	Established Rate of $180
Balance Bill Amount (Cindy's OOP costs[1])	**$0**	**$270**

[1]All dollar amounts in this example and the table are hypothetical and for illustrative purposes only. Out-of-pocket (OOP) costs do not include deductible, copayment, or co-insurance.

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