UnitedHealthcare®

CHOICE PLUS 8CY / H9

Coverage Period: 02/01/2013 - 01/31/2014

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Employee + Family | **Plan Type:** PS1

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myuhc.com or by calling 1-800-377-5154..

Important Questions	Answers	Why This Matters
What is the overall deductible?	Network: **$2,000** Individual* / **$4,000** Family Non-Network: **$4,000** Individual / **$8,000** Family *Doesn't apply if policy covers 2+ people. Does not apply to copays, prescription drugs, and services listed below as "No Charge." Per Policy Year	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the Common Medical Events chart for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services, but see the Common Medical Events chart for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Network: **$4,000** Individual / **$8,000** Family Non-Network: **$8,000** Individual / **$16,000** Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover, penalties for failure to obtain pre-authorization for services, prescription drugs and copays.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The Common Medical Events chart describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see www.myuhc.com or call 1-800-377-5154.	If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the Common Medical Events chart for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed under Services Your Plan Does NOT Cover. See your policy or plan document for additional information about excluded services.

- Co-payments (copays) are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance (co-ins) is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If a Non-Network Provider charges more than the allowed amount, you may have to pay the difference. For example, if a Non-Network Provider hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25.00 copay per visit	40% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	$50.00 copay per visit	40% co-ins	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	$25.00 copay per visit for Manipulative (Chiropractic) Services.	40% co-ins for Manipulative (Chiropractic) Services.	Limited to 24 visits of Manipulative (Chiropractic) Services. Pre-service Notification is required for certain Non-Network services.
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. No coverage non-network.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-ins	40% co-ins	None
	Imaging (CT/PET scans, MRIs)	20% co-ins	40% co-ins	None

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at http://www.aldoi.gov/ .	Tier 1 - Your Lowest-Cost Option	Retail: $10.00 copay Mail-Order: $25.00 copay	Retail: $10.00 copay Mail-Order: Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Tier-1 Contraceptives are covered at No Charge.
	Tier 2 - Your Mid-Range Cost Option	Retail: $30.00 copay Mail-Order: $75.00 copay	Retail: $30.00 copay Mail-Order: Not Covered	If you use a Non-Network Pharmacy, you are responsible for any amount over the allowed amount.
	Tier 3 - Your Highest-Cost Option	Retail: $50.00 copay $125.00 copay	Retail: $50.00 copay Mail-Order: Not Covered	You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 4 - Additional High-Cost Options	Not Applicable	Not Applicable	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-ins	40% co-ins	Per Occurrence Deductible of $250 and Annual Deductible apply.
	Physician/surgeon fees	20% co-ins	40% co-ins	None
If you need immediate medical attention	Emergency room services	$250.00 copay per visit	$250.00 copay per visit	Inpatient Pre-service Notification required Non-Network.
	Emergency medical transportation	20% co-ins	20% co-ins	Pre-service Notification is required for Non-Emergency Ambulance.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
	Urgent care	$100.00 copay per visit	40% co-ins	If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-ins	40% co-ins	Pre-service Notification is required Non network. Per Occurrence Deductible of $500 and Annual Deductible apply.
	Physician/surgeon fees	20% co-ins	40% co-ins	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25.00 copay	40% co-ins	Pre-service Notification is required from the Mental Health/Substance Abuse Disorder Designee.
	Mental/Behavioral health inpatient services	20% co-ins	40% co-ins	Pre-service Notification is required from the Mental Health/Substance Abuse Disorder Designee.
	Substance use disorder outpatient services	$25.00 copay	40% co-ins	Pre-service Notification is required from the Mental Health/Substance Abuse Disorder Designee.
	Substance use disorder inpatient services	20% co-ins	40% co-ins	Pre-service Notification is required from the Mental Health/Substance Abuse Disorder Designee.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If you become pregnant	Prenatal and postnatal care	20% co-ins	40% co-ins	Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	20% co-ins	40% co-ins	Inpatient non-network Authorization may apply.
If you have a recovery or other special health need	Home health care	20% co-ins	40% co-ins	Limited to 100 visits per year. Pre-service notification required Non-Network.
	Rehabilitation services	$25.00 copay per outpatient visit	40% co-ins	Depending upon the type of therapy, there is a limit of 20 -36 visits per policy period. Pre-service Notification is required for certain Non-Network services.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation Services.
	Skilled nursing care	20% co-ins	40% co-ins	Limited to 60 days per year (limit is combined with IP Rehabilitation Services). Pre-service Notification is required Non-Network.
	Durable medical equipment	20% co-ins	40% co-ins	Limited to $2,500 maximum per policy period if the device is determined to be non-essential. Covers 1 per type of DME (including repair/replacement) every 3 years. Pre-service notification required non-network for DME over $1,000.
	Hospice service	20% co-ins	40% co-ins	Inpatient Pre-service notification required Non-Network.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Non-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$25.00 copay per visit	Not Covered	Limited to 1 exam every 2 years. No coverage non-network
	Glasses	Not Covered	Not Covered	No coverage for glasses.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Glasses	• Non-emergency care when traveling outside the U.S.
• Bariatric surgery	• Habilitation Services	• Private-duty nursing
• Cosmetic surgery	• Infertility treatment	• Routine foot care
• Dental care (adult/child)	• Long-term care	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Hearing aids may be covered with limitations	• Routine eye care (adult) may be covered with limitations	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-747-1019. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or visit www.cciio.cms.gov.

Your Grievance and Appeals Rights :

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact your human resource department or the Employee Benefits Security Administration at 1-866-444-3272 or visit www.dol.gov/ebsa/healthreform or California Department of Insurance at 1-800-927-4357 or visit http://www.insurance.ca.gov/.

Additionally, a consumer assistance program may help you file your appeal. Contact California Department of Managed Health Care Help Center at 1-888-466-2219 or visit http://www.healthhelp.ca.gov. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http:///ciio.cms.gov/prgrams/consumer/capgrants/index.html.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación
若需要中文协助，请拨打您会员卡上的电话号码。
Dine k'ehji shich'i' hadoodzih ninizingo, bee neehozin biniiye nanitinigii number bikaa'igii bich'i' hodiilnih
Para sa tulong sa Tagalog, tawagan ang numero sa iyong ID card.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost also will be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- **Amount owed to providers:** $7540
- **Plan Pays 4320**$
- **Patient Pays 3220**$

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7540**
Patient pays:	
Deductibles	$2000
Co-pays	$20
Co-insurance	$1050
Limits or exclusions	$150
Total	**$3220**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5400
- **Plan Pays 2830**$
- **Patient Pays 2570**$

Sample care costs:

Prescriptions	$2900
Medical Equipment and Supplies	$1300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5400**
Patient pays:	
Deductibles	$2000
Co-pays	$430
Co-insurance	$60
Limits or exclusions	$80
Total	**$2570**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If other than individual coverage, the Patient Pays amount may be more.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles** and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.