UnitedHealthcare CA SignatureValue LVH 2LC

Coverage Period: 01/01/2013 – 12/31/2013

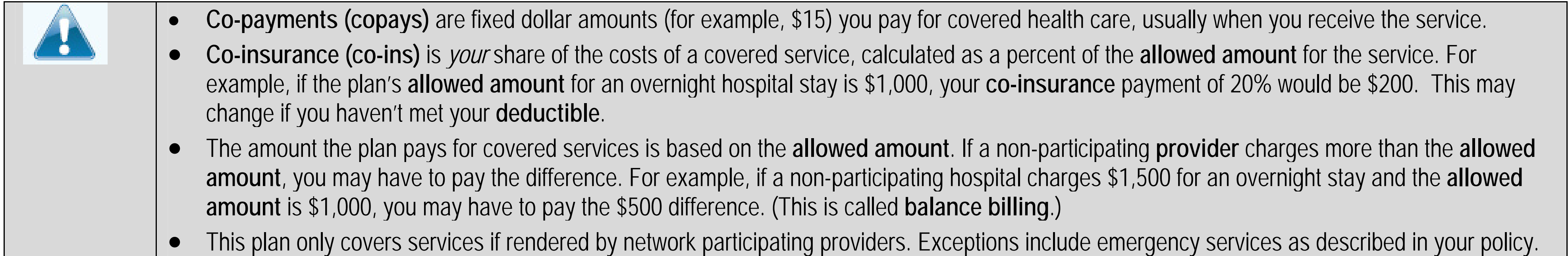
Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Employee/Family **Plan Type:** HMO

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.uhcwest.com or by calling 1-800-624-8822.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating: **$0** Individual/ **$0** Family	See the chart starting on page 2 for your other costs for services this plan covers.
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 chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Participating: **$1,000** Individual / **$3,000** Family	The **out-of-pocket limit** is the most you could pay during a policy period 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, and prescription drugs.	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 insurer pays?	No, this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the insurer will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses participating providers. If you use a non-participating provider your cost may be more. For a list of participating providers, see www.uhcwest.com or call 1-800-624-8822 for a list of participating providers.	If you use a participating doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your participating doctor or hospital may use a non-participating **provider** for some services. Plans use the term in-network, **preferred**, or participating to refer to **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a specialist but only if you have the plan's permission before you see the specialist for covered services.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-624-8822 for Member Services or visit us at www.uhcwest.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the telephone numbers above to request a copy.



- **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-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating 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**.)
- This plan only covers services if rendered by network participating providers. Exceptions include emergency services as described in your policy.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays, deductibles or co-ins may apply.
	Specialist visit	$25 copay per visit	Not Covered	Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copays, deductibles or co-ins may apply.
	Other practitioner office visit	Not Covered	Not Covered	No coverage for Manipulative (Chiropractic) Treatment.
	Preventive care / screening / immunization	$25 copay per visit	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT / PET scans, MRIs)	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.uhcwest.com	Tier 1 – Your Lowest-Cost Option	Retail: $10 copay Mail-Order: $20 copay	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. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 2 – Your Midrange-Cost Option	Retail: $30 copay Mail-Order: $60 copay	Not Covered	
	Tier 3 – Your Highest-Cost Option	Not Applicable	Not Applicable	
	Tier 4 – Additional High-Cost Options	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (example, ambulatory surgery center)	$50 copay	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	$100 copay per visit	$100 copay per visit	Copay not waived if admitted.
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$25 copay per visit	$100 copay per visit	Copay not waived if admitted. 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 (example: hospital room)	$100 copay per admit	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$25 copay per visit	Not Covered	None
	Mental / Behavioral health inpatient services	$100 copay per admit	Not Covered	None
	Substance use disorder outpatient services	$25 copay per visit	Not Covered	None
	Substance use disorder inpatient services	$100 copay per admit	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Additional copays, deductibles or co-ins may apply. Routine pre-natal care is covered at No Charge.
	Delivery and all inpatient services	$100 copay per admit	Not Covered	Additional copays, deductibles or co-ins may apply.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Limited to 100 visits per calendar year.
	Rehabilitation services	$25 copay per visit	Not Covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitation services	Not Covered	Not Covered	No coverage for Habilitation services.
	Skilled nursing care	$100 copay per admit	Not Covered	Limited to 100 consecutive calendar days from the first treatment per disability.
	Durable medical equipment	No Charge	Not Covered	Limited to $5,000 Benefit Maximum per Calendar year.
	Hospice service	$100 copay per admit	Not Covered	None
If your child needs dental or eye care	Eye exam	$25 copay per visit	Not Covered	1 exam every 12 months.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-ups.

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 • Chiropractic care • Cosmetic Surgery • Dental Care (Adult/Child) • Glasses – may be covered with limitations	• Habilitative Treatment • Infertility Treatment - may be covered with limitations • Long-term care • Non-emergency care when traveling outside the U.S	• Private-duty nursing • Routine foot 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.)		
• Bariatric Surgery	• 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 1-800-624-8822. 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 http://www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-877-267-2323x1565 or visit http://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 Department of Managed Health Care at 1-888-466-2219 or visit http://www.healthhelp.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.

----------------------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.* ---------------------

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 of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,140
- **Patient pays** $400

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$200
Co-insurance	$0
Limits or exclusions	$200
Total	**$400**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,320
- **Patient pays** $1,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment & Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$1,000
Co-insurance	$0
Limits or exclusions	$80
Total	**$1,080**

Questions and answers about 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-participating **providers**. If the patient had received care from out-of-participating **providers**, costs would have been higher.

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.

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