UnitedHealthcare®

COVERED CALIFORNIA

So many ways into the complex health care system.

One guide to make shopping for health care coverage simpler.

welcome to

simpler

coverage shopping

Use this guide to find coverage for you and your family. It's easier than you might think. And we're here to help.

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Let's get started.

Finding health care coverage that's right for you can be as easy as **1, 2, 3.**

How to choose coverage.

Learn how to compare coverage plans and when to sign up.

Compare plans.

Look closely at the plans to see which one's right for you.

What comes next?

Get your health care coverage and find out what happens next.

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1 How to choose coverage.

3 key decisions.

1) Choose any doctor or specialist in the network.

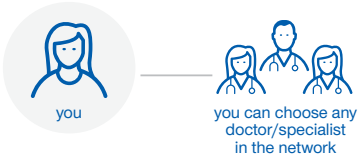
These plans give you the choice to see any network doctor or specialist without a referral. Using the network always saves you money.

Core PPO Plans

You can go directly to any provider in or out of the network, but staying in the network saves you money.

Core Essential EPO Plans

You can go directly to any doctor in the network. There is no coverage if you see a doctor or specialist that is out of the network.



2) Pick a coverage plan level.

The Affordable Care Act created four categories (or metal levels) of coverage plans. You'll need to consider how often you go to the doctor and your budget for monthly premium, deductible and co-pays.

	Bronze	Silver	Gold	Platinum
Monthly Premium	$	$$	$$$	$$$$
Your Co-pay (cost per visit/drug)	$$$$	$$$	$$	$
Consider this plan category if:	You rarely see a doctor, and you're willing to pay a higher co-pay when you do.	You want to balance monthly premium, co-pay and deductible costs.		You see doctors more often and are willing to pay higher monthly premiums to lower your co-pay.

If your income is between 100 and 250 percent of the federal poverty level, you may be able to get a Cost Share Reduction plan. These plans are available only with Silver ACA Health Plans and lower the out-of-pocket expenses you pay for deductibles, co-pays and co-insurance.

3) Check prescription drug costs and coverage.

Check to see if your medications are covered and how much they cost in each metal level plan.

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Other considerations.

We're working hard to make it simpler to use your health care coverage.

Great coverage in every plan.

These plans cover 10 essential benefits, preventive care and pre-existing conditions.

Preventive Care
Checkups, flu shots & vaccinations.

Essential Benefits
Prescriptions, ER care & lab tests.

Ways to save.

Subsidies
87 percent of people saved an average of $264 a month with a marketplace plan.*

Cost Estimates
Check prices for procedures before you get care.

Easy access to health care.

These plans come with a network of doctors, clinics and hospitals. Plus these tools to help you manage your care anytime, anywhere.

24-hour NurseLine℠
Ready to help anytime you need us.

Virtual ID Card
Available on our free Health4Me app.

24/7 Benefit Access
At home or on-the-go.

* Projected savings based on qualification for a federal tax credit subject to verification upon filing an individual's federal tax return. See Premium Affordability, Competition and Choice in the Health Insurance Marketplace, 2014, June 18, 2014, Department of HHS. Actual savings may vary.

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Core PPO Plans

Core PPO plans give you a nationwide network and open access to in- and out-of-network providers.

How does it work? You can see any provider in or out of the network, but you save money by using doctors, clinics and hospitals in the network. If you go to a provider that is out of network, there will be some coverage but you will likely pay more. There's no need to choose a primary care provider (PCP) or get referrals to specialists, but you may like having a PCP to help coordinate your care.

Get the most from your plan by using the network and working with a PCP.

The Core PPO Network

Core PPO plans let you see specialists without a referral, and you can get care from any provider or facility within the network in your local area, throughout California and neighboring states, not just in the counties listed below.

Core PPO plans are available in the following counties:

Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Fresno, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Mendocino, Modoc, Mono, Monterey, Nevada, Plumas, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Ventura, Yuba

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2 Compare plans

UnitedHealthcare Benefits Plan of California
Covered California

Core PPO co-pay plans

You're not sure how often you'll see a doctor, so you'd like a predictable co-pay to help manage your budget.

	Bronze 60 PPO Covers **60%** average annual cost	Silver 70 PPO Covers **70%** average annual cost
Your Monthly Payment	$	$$
Your Co-pay (cost per visit/drug)	$$$$	$$$
Deductible and Annual Out-of-Pocket Maximum		
Deductible (Individual) / (Family)	$6,000 medical, $500 drug / $12,000 medical, $1,000 drug	$2,250 medical, $250 drug / $4,500 medical, $500 drug
Annual Out-of-Pocket Maximum (Individual)/(Family)	$6,500 / $13,000 family	$6,250 / $12,500 family
Medical Cost Shares		
Annual Wellness Exam	No Charge	No Charge
Primary Care Visit	$70*	$45
Specialty Care Visit	$90*	$70
Urgent Care Visit	$120*	$90
Emergency Room Facility	100% until medical deductible is met	$250 once medical deductible is met
Laboratory Tests	$40	$35
X-Ray and Diagnostics	100% until medical deductible is met	$65
Outpatient Surgery	100% until medical deductible is met	20%
Hospital Stay, Maternity Stay	100% until medical deductible is met	20% after deductible is met
Drug Cost Shares – 30-day supply		
Tier 1	up to $500, after deductible is met	$15
Tier 2	up to $500, after deductible is met	$50 after drug deductible
Tier 3	up to $500, after deductible is met	$70 after drug deductible
Tier 4	up to $500, after deductible is met	20% up to $250 after drug deductible

Benefits shown in blue are not subject to a deductible.
*Co-pay is for any combination of the first three visits. A member pays 100% until deductible is met.

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UnitedHealthcare Benefits Plan of California
Covered California

Core PPO co-pay plans

You're not sure how often you'll see a doctor, so you'd like a predictable co-pay to help manage your budget.

	Gold 80 PPO Covers **80%** average annual cost	Platinum 90 PPO Covers **90%** average annual cost
Your Monthly Payment	$$$	$$$$
Your Co-pay (cost per visit/drug)	$$	$
Deductible and Annual Out-of-Pocket Maximum		
Deductible (Individual) / (Family)	N/A	N/A
Annual Out-of-Pocket Maximum (Individual)/(Family)	$6,200 / $12,400 family	$4,000 / $8,000 family
Medical Cost Shares		
Annual Wellness Exam	No Charge	No Charge
Primary Care Visit	$35	$20
Specialty Care Visit	$55	$40
Urgent Care Visit	$60	$40
Emergency Room Facility	$250	$150
Laboratory Tests	$35	$20
X-Ray and Diagnostics	$50	$40
Outpatient Surgery	20%	10%
Hospital Stay, Maternity Stay	20%	10%
Drug Cost Shares – 30-day supply		
Tier 1	$15	$5
Tier 2	$50	$15
Tier 3	$70	$25
Tier 4	20% up to $250	10% up to $250

Benefits shown in blue are not subject to a deductible.

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Core PPO health savings account (HSA) plans

You rarely see a doctor. The tax-advantaged savings account puts your money to work for you. Consult your tax advisor if you have questions.

	Bronze HSA 60 PPO Covers **60%** average annual cost
Your Monthly Payment	$
Your Co-pay (cost per visit/drug)	$$$$
Deductible and Annual Out-of-Pocket Maximum	
Deductible (Individual) / (Family)	$4,500 / $9,000, Integrated
Annual Out-of-Pocket Maximum (Individual)/(Family)	$6,500/ $13,000
Medical Cost Shares	
Annual Wellness Exam	No Charge
Primary Care Visit	40%
Specialty Care Visit	40%
Urgent Care Visit	40%
Emergency Room Facility	40%
Laboratory Tests	40%
X-Ray and Diagnostics	40%
Outpatient Surgery	40%
Hospital Stay, Maternity Stay	40%
Drug Cost Shares – 30-day supply	
Tier 1	40%
Tier 2	40%
Tier 3	40%
Tier 4	40%

Benefits shown in blue are not subject to a deductible.

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Core Essential EPO Plans

Core Essential EPO plans give you a nationwide network and open access to in-network providers.

How does it work? You can see any provider in the network. There's no need to choose a primary care provider (PCP) or get referrals to specialists, but you may like having a PCP to help coordinate your care.

Get the most from your plan by working with a PCP.

The Core Essential EPO Network

Core Essential EPO plans let you see specialists without a referral, and you can get care from any provider or facility within the network in your local area, throughout California and neighboring states, not just in the counties listed below.

Core Essential EPO plans are available in the following counties:

Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Fresno, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Mendocino, Modoc, Mono, Monterey, Nevada, Plumas, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Ventura, Yuba

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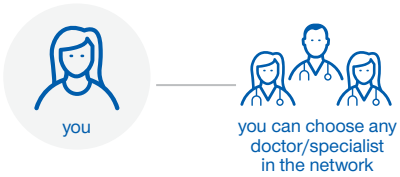
2 Compare plans

UnitedHealthcare Benefits Plan of California
Covered California

Core Essential EPO catastrophic plans

Designed for people under 30 or those with hardship exemptions from high medical costs. Find out if you're eligible at coveredca.com



	Minimum Coverage EPO Covers **60%** average annual cost
Your Monthly Payment	$
Your Co-pay (cost per visit/drug)	$$$$
Deductible and Annual Out-of-Pocket Maximum	
Deductible (Individual) / (Family)	$6,850 / $13,700 family, Integrated
Annual Out-of-Pocket Maximum (Individual)/(Family)	$6,850 / $13,700
Medical Cost Shares	
Annual Wellness Exam	No Charge
Primary Care Visit	0%*
Specialty Care Visit	0%
Urgent Care Visit	0%*
Emergency Room Facility	0%
Laboratory Tests	0%
X-Ray and Diagnostics	0%
Outpatient Surgery	0%
Hospital Stay, Maternity Stay	0%
Drug Cost Shares – 30-day supply	
Tier 1	0%
Tier 2	0%
Tier 3	0%
Tier 4	0%

Benefits shown in blue are not subject to a deductible.
*Co-pay is for any combination of the first three visits. A member pays 100% until deductible is met.

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3 What comes next?

Sign up.

Nov. 1, 2015 - Jan. 31, 2016

Choose a plan.

See your monthly premium.

Learn about financial help.

Use this simple sign-up checklist.
Have everything ready for everyone you're covering.

- ✓ Social security number
- ✓ Employer and income information (pay stubs, W-2s or tax statements)
- ✓ Policy numbers for current health care coverage, if you have it
- ✓ Proof of legal residency

Before your coverage starts.

What we're doing:

Setting up your coverage.

Reviewing your information. We'll contact you if we need any additional information.

Creating your ID card. We will send it to you with directions on how to activate your health care coverage.

What you can do:

Look for network doctors, clinics and hospitals in your area at myuhc.com

Keep an eye out for your first bill. Your sign-up is complete after you've paid this bill.

Sign up now:

Open Enrollment: Nov. 1, 2015 – Jan. 31, 2016
Special Enrollment: After Jan. 31, 2016

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Coverage starts.

Sign up by		Earliest coverage starts
12/15/15	-	1/1/16
1/15/16	-	2/1/16
1/31/16	-	3/1/16

Look for your welcome kit and ID card in the mail.

Check out your ID card.

Look at your ID card to make sure your information is correct. Use this card every time you go to the doctor or pick up a prescription.

What to do before you visit a doctor:

Core PPO Plans

You can see any doctor in or out of the network , but you save money by using doctors, clinics and hospitals in the network.

Core Essential EPO Plan

You can see any doctor in the network. Be sure to seek care in the network to make sure your visits are covered.

Find a doctor at myuhc.com

Have a question?

Call the number on your ID card or on myuhc.com

Use your coverage.

Remember to get preventive care like checkups and flu shots.

Use the tools below to manage your health and costs.

24-hour NurseLine

Call the toll-free NurseLine number on your ID card anytime.

Health Care Coverage App

View your ID card, get health and account info, find doctors and talk to a nurse with Health4Me.

Price Checker Tool

Shop doctors, clinics and hospitals to find the best price at myuhc.com

Personalized Member Website

Manage your insurance info, print ID cards, find doctors and access health tools. Sign up at myuhc.com

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Glossary

It's easier to choose health care coverage when you understand a few key words.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe.

For Example: If the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Co-pay

A fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

For Example: You pay $15 for a doctor visit.

Covered

Refers to health care your insurance company includes in your plan.

Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.

For Example: If your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

HSA

A bank account that lets people put money aside, tax-free, to save and pay for health care expenses. The Internal Revenue Service (IRS) limits who can open and put money into an HSA.

Marketplace

An online store for health insurance sometimes called an Exchange. You can browse and compare plans from different insurance companies, then sign up for the one you want.

Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Out-of-pocket max (OOP maximum)

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Pharmacy Tiers

Pharmacy tiers divide the list of covered medications into groups. Each group has a different co-insurance percentage or co-pay.

- You save money by using medications in tier one (lowest co-insurance), which usually includes generic drugs.
- The second tier (higher co-insurance) includes preferred brand-name medications.
- The third tier (highest co-insurance) includes non-preferred brand-name medications.
- For tier four medications, you pay a co-pay or co-insurance based on your plan benefits.

PCP

A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Premium

The amount that must be paid for your health insurance or plan. You usually pay it monthly, quarterly or yearly.

Provider

A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

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Let's look at the fine print.

Core PPO exclusions and limitations

This is not a complete list of excluded or limited services, treatments, visit limits, items and supplies. Please review the sample "Individual Medical Contract" found at uhc.com/individual-and-family/medical-policy for a complete list.

Exclusions and limitations:

- Out-of-network care are services received from a doctor or hospital that does not have a contract with the health plan or provider network. Out-of-network care services received from a doctor or hospital that does not have a contract with the health plan will result in you paying more out of pocket expenses.
- Charges in excess of Eligible Expenses or in excess of any specified limitation.
- Pediatric dental and vision limited to benefits as described in the medical contract.
- Outpatient Prescription Drug Products obtained from a non-Network Pharmacy except as required for Urgently Needed Care or Emergency treatment.
- Coverage for Prescription Drug Products which is less than or exceeds the supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Urgently Needed Care or Emergency treatment.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Prescription Drug Products when prescribed to treat infertility.
- Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider unless prior authorized as Medically Necessary.
- Growth hormone therapy except as Medically Necessary.
- Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.
- In vitro fertilization regardless of the reason for treatment.
- Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage, adoption, related to judicial or administrative proceedings or orders, conducted for purposes of medical research, or are required to obtain or maintain a license of any type.
- Services or supplies that are Experimental or Investigational, except routine costs associated with qualifying clinical trials.

Let's look at the fine print.

Core Essential EPO exclusions and limitations

This is not a complete list of excluded or limited services, treatments, visit limits, items and supplies. Please review the sample "Individual Medical Contract" found at uhc.com/individual-and-family/medical-policy for a complete list.

Exclusions and limitations:

- Charges in excess of Eligible Expenses or in excess of any specified limitation.
- Pediatric dental and vision limited to benefits as described in the medical contract.
- Outpatient Prescription Drug Products obtained from a non-Network Pharmacy except as required for Urgently Needed Care or Emergency treatment.
- Coverage for Prescription Drug Products which exceeds the supply limit.
- Prescription Drug Products dispensed outside the United States, except as required for Urgently Needed Care or Emergency treatment.
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Prescription Drug Products when prescribed to treat infertility.
- Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider unless prior authorized as Medically Necessary.
- Growth hormone therapy except as Medically Necessary.
- Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.
- In vitro fertilization.
- Services performed by a provider who is a family member by birth or marriage.
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage, adoption, related to judicial or administrative proceedings or orders, conducted for purposes of medical research, or are required to obtain or maintain a license of any type.
- Services or supplies that are Experimental or Investigational, except routine costs associated with qualifying clinical trials.

But wait, there's more.

Core additional provisions

Adjustments to premium

We reserve the right to change the schedule or premiums on January 1 of each year. We will give you written notice of any premium change 60 days prior to the change date.

Events terminating your coverage

Coverage ends on the earliest of these dates:

The contract terminates

Your coverage ends on the date this contract ends. That date will be one of the following:

- The date determined by the federal health benefit exchange because you no longer live in the service area.
- The date we specify, after giving you 90 days written notice, because we are discontinuing all policies with the same type and level of benefits for your state.
- The date we specify, after giving you and the state authority at least 180 days written notice, that we are discontinuing policies/certificates in the individual market in your state.

You are no longer eligible

Your coverage ends on the date you are no longer eligible to be an enrolled dependent, as determined by Covered California. The dependent must meet the definition under the policy for an eligible dependent and is subject to any applicable age restrictions.

We receive notice to end coverage

Your coverage ends on the date determined by Covered California rules if we receive notice from them or you instructing us to end your coverage.

Other events ending your coverage

When any of the following happen, we will provide you written notice that coverage ended on an identified date:

Failure to pay

You fail to pay your premium.

Fraud or intentional misrepresentation of a material fact

You committed an act, practice or omission that constitutes fraud, or an intentional misrepresentation of a material fact. Example: Knowingly providing incorrect information about another person's eligibility or status as a dependent.

If we find you have performed an act, practice or omission that constitutes fraud, or made an intentional misrepresentation of material fact, we have the right to demand pay back of all benefits we paid to you or in your name during the time you were incorrectly covered under the contract.

You accepted reimbursement for premium

You accept any direct or indirect contribution or reimbursement by or on behalf of any third party. This includes, but is not limited to, any health care provider or any portion of the premium for coverage under this contract. Does not apply to the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act
- Indian tribes, tribal organization or urban Indian organizations
- State and federal government programs

notes

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notes

Feeling stressed? Make this page your cheat sheet. Jot down notes about the plan; your prescriptions; and doctors, clinics and hospitals in your network.

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Shopping for health care coverage just got simpler.

That's why 45 million Americans rely on UnitedHealthcare for their health coverage.*

UnitedHealthcare serves 45 million domestically and internationally through its market facing business. Source: UnitedHealth Group 2014 Annual Report, pg. 6.

This coverage is not designed or marketed as employer-provided insurance. It does not comply with California small employer group health insurance laws. These plans cannot be used, now or in the future, by you or an employer to provide insurance for employees.

This is an outline only and is not intended to serve as legal interpretation of benefits. Reasonable effort has been made to have this outline represent the intent of the contract language. However, the contract language stands alone and the complete terms of the coverage will be determined by the policy.

Core PPO and Core Essential EPO plans offered by **UnitedHealthcare Benefits Plan of California.**

Subject to all policy provisions. To be considered for reimbursement, expenses must qualify as covered expenses. Expenses are subject to eligible expense limits unless you use a network provider.

Policy numbers in this document:
37873CA0010001-01, 37873CA0010002-01, 37873CA0010003-01, 37873CA0010004-01, 37873CA0010005-01, 37873CA0020001-01

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