UnitedHealthcare California Small Business (2–50) Plan Benefit & Administration Changes

For groups renewing October 1, 2010 and after

Current Plan Name	New Plan Name (Upon Renewal)	Benefit Description	Current Benefit	New Benefit (Upon Renewal)
All UnitedHealthcare Choice Plus Traditional with Deductible Plans	Not applicable	Outpatient Lab, X-ray and Diagnostics	No Copayment	Deductible and Coinsurance
		Emergency Health Services	$150 Copayment	$250 Copayment
		Urgent Care Center Services (in-network Copayment)	$75 Copayment	$125 Copayment
		Outpatient Prescription Drugs	$10/$35/$60	$15/$35/$60 ($15/25%/30% for Specialty Medications)
		Maximum Policy Benefit	$5,000,000	Unlimited
		Preventive Care Services	Office Visit Copayment or Deductible and Coinsurance, Not Covered Out-of-network	100% In-network, Not Covered Out-of-network
UnitedHealthcare Choice Plus Traditional with Deductible 40/500/70%	No change	Out-of-Pocket Maximum (in-network)	$5,000 Individual; $10,000 Family	$4,000 Individual; $8,000 Family
		Out-of-Pocket Maximum (out-of-network)	$10,000 Individual; $20,000 Family	$8,000 Individual; $16,000 Family
All UnitedHealthcare Choice Plus Balanced Plans	Not applicable	Outpatient Lab, X-ray and Diagnostics	No Copayment	Deductible and Coinsurance
		Emergency Health Services	$200 Copayment	$250 Copayment
		Urgent Care Center Services (in-network Copayment)	$100 Copayment	$125 Copayment
		Outpatient Prescription Drugs	$10/$35/$60 after $150 Individual; $450 Family deductible on tier II and III drugs	$15/$35/$60 ($15/25%/30% for Specialty Medications) after $150 Individual; $450 Family deductible on tier II and III drugs
		Maximum Policy Benefit	$5,000,000	Unlimited
		Preventive Care Services	Office Visit Copayment or Deductible and Coinsurance, Not Covered Out-of-network	100% In-network, Not Covered Out-of-network
UnitedHealthcare Choice Plus Balanced 30/1000/80%	No change	Out-of-Pocket Maximum (in-network)	$4,000 Individual; $8,000 Family	$5,000 Individual; $10,000 Family
		Out-of-Pocket Maximum (out-of-network)	$8,000 Individual; $16,000 Family	$10,000 Individual; $20,000 Family

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Current Plan Name	New Plan Name (Upon Renewal)	Benefit Description	Current Benefit	New Benefit (Upon Renewal)
All UnitedHealthcare Choice Plus Balanced VALUE Plans	Not applicable	Per Occurrence Deductible for Inpatient Hospital and Outpatient Surgery	Included in the Out-of-Pocket Maximum	Not included in the Out-of-Pocket Maximum
		Outpatient Prescription Drugs	$10/$35/$60 after $250 Individual; $750 Family deductible	$20/$40/$60 ($20/25%/30% for Specialty Medications) after $250 Individual; $750 Family deductible
		Maximum Policy Benefit	$5,000,000	Unlimited
		Preventive Care Services	Office Visit Copayment or Deductible and Coinsurance, Not Covered Out-of-network	100% In-network, Not Covered Out-of-network
All UnitedHealthcare Choice Plus Definity℠ HSA Plans	Not applicable	Outpatient Prescription Drugs	$10/$30/$50 after Annual Deductible	$15/$35/$60 ($15/25%/30% for Specialty Medications) after Annual Deductible
		Maximum Policy Benefit	$5,000,000	Unlimited
UnitedHealthcare Choice Plus Definity HSA 2000/100%	No change	Benefit Plan Coinsurance (the amount UnitedHealthcare pays)	100% In-network; 80% Out-of-network	100% In-network; 70% Out-of-network
UnitedHealthcare Choice Plus Definity HSA 1500/80%	No change	Benefit Plan Coinsurance (the amount UnitedHealthcare pays)	80% In-network; 60% Out-of-network	80% In-network; 50% Out-of-network
UnitedHealthcare Choice Plus Definity HSA 2850/80%	UnitedHealthcare Choice Plus Definity HSA 2000/80%	Benefit Plan Coinsurance (the amount UnitedHealthcare pays)	80% In-network; 60% Out-of-network	80% In-network; 50% Out-of-network
		Deductible (in-network)	$2,850 Individual; $5,600 Family	$2,000 Individual; $4,000 Family
		Deductible (out-of-network)	$5,000 Individual; $10,000 Family	$4,000 Individual; $8,000 Family
		Family Deductible	Embedded (plan D6-I)	Non-embedded
		Out-of-Pocket Maximum (in-network)	$3,500 Individual; $7000 Family	$4,000 Individual; $8,000 Family
		Out-of-Pocket Maximum (out-of-network)	$10,000 Individual; $20,000 Family	$8,000 Individual; $16,000 Family
UnitedHealthcare Choice Plus Definity HSA 3000/70%	UnitedHealthcare Choice Plus Definity HSA 3000/80%	Benefit Plan Coinsurance	70% In-network; 50% Out-of-network	80% In-network; 50% Out-of-network
		Family Deductible	Embedded	Non-embedded
UnitedHealthcare Choice Plus Definity HSA 3500/70%	UnitedHealthcare Choice Plus Definity HSA 4000/80%	Benefit Plan Coinsurance (the amount UnitedHealthcare pays)	70% In-network; 50% Out-of-network	80% In-network; 50% Out-of-network
		Deductible (in-network)	$3,500 Individual; $7,000 Family	$4,000 Individual; $8,000 Family
		Deductible (out-of-network)	$7,000 Individual; $14,000 Family	$8,000 Individual; $16,000 Family
All UnitedHealthcare Choice Plus Definity HRA Plans	Not applicable	Outpatient Prescription Drugs	$10/$35/$60 after $250 Individual; $750 Family deductible on tier II and III drugs	$15/$35/$60 ($15/25%/30% for Specialty Medications) after $250 Individual; $750 Family deductible on tier II and III drugs
		Maximum Policy Benefit	$5,000,000	Unlimited

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For groups renewing October 1, 2010 and after

Current Plan Name	New Plan Name (Upon Renewal)	Benefit Description	Current Benefit	New Benefit (Upon Renewal)
UnitedHealthcare Non-Differential PPO 2000/80%	No change	Outpatient Prescription Drugs	$10/$35/$60 after $150 Individual; $450 Family deductible on tier II and III drugs	$15/$35/$60 ($15/25%/30% for Specialty Medications) after $150 Individual; $450 Family deductible on tier II and III drugs
		Maximum Policy Benefit	$5,000,000	Unlimited
		Preventive Care Services	Office Visit Copayment or Deductible and Coinsurance, Not Covered Out-of-network	100% In-network, Not Covered Out-of-network
All UnitedHealthcare SignatureValue™ (HMO) and UnitedHealthcare SignatureValue™ Advantage (HMO) Plans	Not applicable	Immunizations	Office Visit Copayment	Paid in Full
		Periodic Health Evaluations	Office Visit Copayment	Paid in Full
		Well-Woman Care	Office Visit Copayment	Paid in Full
		Bone Marrow Transplants - Donor Searches	$15,000 per procedure benefit limit	No per procedure benefit limit
		Inpatient Hospital Benefits - Autologous Blood	$120 per unit benefit limit	No per unit benefit limit
UnitedHealthcare SignatureValue (HMO) 10-30/100 **UnitedHealthcare SignatureValue Advantage (HMO) 10-30/100**	UnitedHealthcare SignatureValue (HMO) 10-30/100% UnitedHealthcare SignatureValue Advantage (HMO) 10-30/100%	Emergency Services	$100 Copayment	$150 Copayment
		Urgently Needed Services	$50 Copayment	$75 Copayment
		Crisis Intervention	$35 Copayment (20 visits)	Not covered
UnitedHealthcare SignatureValue (HMO) 15-30/300a **UnitedHealthcare SignatureValue Advantage (HMO) 15-30/300a**	No change	Emergency Services	$100 Copayment	$150 Copayment
		Urgently Needed Services	$50 Copayment	$75 Copayment
		Crisis Intervention	$35 Copayment (20 visits)	Not covered
UnitedHealthcare SignatureValue (HMO) 15-30/300a **UnitedHealthcare SignatureValue Advantage (HMO) 15-30/300a**	No change	Emergency Services	$100 Copayment	$150 Copayment
		Urgently Needed Services	$50 Copayment	$75 Copayment
		Crisis Intervention	$35 Copayment (20 visits)	Not covered
UnitedHealthcare SignatureValue (HMO) 10-30/500d **UnitedHealthcare SignatureValue Advantage (HMO) 10-30/500d**	UnitedHealthcare SignatureValue (HMO) 20-40/300d UnitedHealthcare SignatureValue Advantage (HMO) 20-40/300d	PCP Office Visits	$10 Copayment	$20 Copayment
		Specialist/Nonphysician Health Care Practitioner Office Visits	$30 Copayment	$40 Copayment
		Inpatient Hospital Benefits	$500 per day; Copayment applies to a maximum of 2 days per stay	$300 per day; Copayment applies to a maximum of 2 days per stay
		Outpatient Surgery	$400 Copayment	$300 Copayment
		Crisis Intervention	$35 Copayment (20 visits)	Not covered
UnitedHealthcare SignatureValue (HMO) 20-40/500d **UnitedHealthcare SignatureValue Advantage (HMO) 20-40/500d**	UnitedHealthcare SignatureValue (HMO) 30-40/500d UnitedHealthcare SignatureValue Advantage (HMO)30-40/500d	PCP Office Visits	$20 Copayment	$30 Copayment
		Crisis Intervention	$35 Copayment (20 visits)	Not covered

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UnitedHealthcare SignatureValue (HMO) 35-45/600d **UnitedHealthcare SignatureValue Advantage (HMO) 35-45/600d**	UnitedHealthcare SignatureValue (HMO) 40-60/800d UnitedHealthcare SignatureValue Advantage (HMO) 40-60/800d	Annual Copayment Maximum	$5,000 Individual; $15,000 Family	$4,000 Individual; $12,000 Family
		PCP Office Visits	$35 Copayment	$40 Copayment
		Specialist/Nonphysician Health Care Practitioner Office Visits	$45 Copayment	$60 Copayment
		Inpatient Hospital Benefits	$600 per day; Copayment applies to a maximum of 4 days per stay	$800 per day; Copayment applies to a maximum of 4 days per stay
		Injectable Drugs	$100 Copayment	$150 Copayment
		Outpatient Mental Health Services (SMI)	$60 Copayment	$40 Copayment
		Home Health Care	$10 Copayment	$15 Copayment
UnitedHealthcare SignatureValue (HMO) Advantage 40-60/2000ded	No change	Injectable Drugs	$100 Copayment	$150 Copayment
		Inpatient Mental Health Services (SMI)	$250 Copayment	Paid in full
UnitedHealthcare SignatureValue (HMO) 40-60/60% **UnitedHealthcare SignatureValue Advantage (HMO) 40-60/60%**	Not applicable	Inpatient Mental Health Services (SMI)	$250 Copayment	40% Copayment
		Outpatient Mental Health Services (SMI)	$60 Copayment	$40 Copayment
UnitedHealthcare SignatureValue (HMO) 20-40/70%/1500ded **UnitedHealthcare SignatureValue Advantage (HMO) 20-40/70%/1500ded**	Not applicable	Inpatient Mental Health Services (SMI)	$250 Copayment	30% Copayment
UnitedHealthcare SignatureValue (HMO) 40-60/70%/2000ded **UnitedHealthcare SignatureValue Advantage (HMO) 40-60/70%/2000ded**	Not applicable	Inpatient Mental Health Services (SMI)	$250 Copayment	30% Copayment
		Outpatient Mental Health Services (SMI)	$60 Copayment	$40 Copayment
UnitedHealthcare SignatureValue (HMO) featuring HealthCare Partners Network 25-50/500ded	Not applicable	Inpatient Mental Health Services (SMI)	$250 Copayment	20% Copayment
		Outpatient Mental Health Services (SMI)	$50 Copayment	$40 Copayment
UnitedHealthcare SignatureValue (HMO) featuring HealthCare Partners Network 25-75/500ded	Not applicable	Inpatient Mental Health Services (SMI)	$250 Copayment	20% Copayment
		Outpatient Mental Health Services (SMI)	$75 Copayment	$40 Copayment
UnitedHealthcare SignatureValue (HMO) featuring HealthCare Partners Network 25-75/1500ded	Not applicable	Inpatient Mental Health Services (SMI)	$250 Copayment	40% Copayment
		Outpatient Mental Health Services (SMI)	$75 Copayment	$40 Copayment

This document is intended only to highlight changes in your benefits and should not be relied upon to fully determine your coverage. If this document conflicts in any way with the plan documents, i.e., the *Combined Evidence of Coverage and Disclosure Form (EOC/DF)* or *Certificate of Coverage (COC)* including the *Schedule of Benefits* and any amendment(s), the plan document shall prevail. Your plan document provides the terms and conditions of your coverage with UnitedHealthcare, and all applicants have a right to review this document prior to enrollment. Upon request, a copy of the plan document will be provided to all potential enrollees prior to enrollment.

Health plan coverage provided by or through UnitedHealthcare Insurance Company and UnitedHealthcare of California. Administrative services provided by PacifiCare Health Plan Administrators, Inc., Prescription Solutions or OptumHealth Care Solutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

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