UnitedHealthcare®

UnitedHealthcare SignatureValue™ Alliance Offered by UnitedHealthcare of California

15-30/300a

HMO Schedule of Benefits

These services are covered as indicated when authorized through your Primary Care Physician in your Participating Medical Group.

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Copayment Maximum[1] (2 individual maximum per family[6])	$1,500/individual
PCP Office Visits	$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits[2] (Member required to obtain referral to specialist or nonphysician health care practitioner, except for OB/GYN Physician services and Emergency/Urgently Needed Services)	$30 Office Visit Copayment
Hospital Benefits (Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.)	$300 Copayment per admit
Emergency Services (Copayment waived if admitted)	$150 Copayment
Urgently Needed Services (Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment waived if admitted)	$75 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	$300 Copayment per admit
Cancer Clinical Trials[3]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	$300 Copayment per admit
Hospital Benefits[4] (Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment)	$300 Copayment per admit
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	$300 Copayment per admit
Maternity Care[8]	$300 Copayment per admit

Benefits Available While Hospitalized as an Inpatient (Continued)

Mental Health Services Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.) (Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment)	$250 Copayment per admit
Newborn Care[4]	$300 Copayment per admit
Physician Care	Paid in full
Reconstructive Surgery	$300 Copayment per admit
Rehabilitation Care (Including physical, occupational and speech therapy)	$300 Copayment per admit
Skilled Nursing Facility Care (Up to 100 consecutive calendar days from the first treatment per disability)	$100 Copayment per day
Voluntary Termination of Pregnancy (Medical/medication and surgical) 1st trimester 2nd trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	 $125 Copayment $200 Copayment

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	 $15 Office Visit Copayment $30 Office Visit Copayment
Ambulance (Only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance copayment.)	$100 Copayment
Cancer Clinical Trials[3]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices[5] (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	$30 Copayment per item
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	$30 Copayment
Dialysis (Physician office visit Copayment may apply)	$30 Copayment per treatment
Durable Medical Equipment[5] ($2,000 annual benefit maximum per calendar year.) The annual DME benefit maximum does not apply to nebulizers, masks, tubing and peak flow meters for the treatment of asthma for Dependent children under the age of 19.	$50 Copayment per item
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children under the age of 19.)	50% Copayment

Benefits Available on an Outpatient Basis (Continued)

Family Planning (Non-Preventive Care)[9]	
Vasectomy	$50 Copayment
Depo-Provera Injection – (other than contraception)[9]	
PCP Office Visit	$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	$30 Office Visit Copayment
Depo-Provera Medication – (other than contraception)[9] (Limited to one Depo-Provera injection every 90 days.)	$35 Copayment
Voluntary Termination of Pregnancy (Medical/medication and surgical)	
1st trimester	$125 Copayment
2nd trimester (12-20 weeks)	$200 Copayment
– After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	
Hearing Aid - Standard $2,500 annual benefit maximum per calendar year. Limited to one hearing aid (including repair/replacement) per hearing-impaired ear every three years.	$50 Copayment
Hearing Aid - Bone Anchored[7] Limited to a single hearing aid during the entire period of time the Member is enrolled in the Health Plan (per lifetime). Repairs and/or replacement are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.	Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits.
Hearing Exam[2,8]	
PCP Office Visit	$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit[2]	$30 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	$15 Copayment per visit
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full
Infertility Services[11]	50% Copayment
Infusion Therapy[5] (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter)	$100 Copayment
Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)[5,9] (Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. The Self-Injectable medications Copayment applies per 30 days or treatment plan, whichever is shorter. Please see the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any. Office visit Copayment may also apply)	$150 Copayment per visit
Laboratory Services (When available through or authorized by your Participating Medical Group)	Paid in full
Maternity Care, Tests and Procedures[8]	
PCP Office Visit	Paid in full
Specialist/Nonphysician Health Care Practitioner Office Visit	Paid in full

Benefits Available on an Outpatient Basis (Continued)

Mental Health Services	
Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.**)	$30 Office Visit Copayment
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	
PCP Office Visit	$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	$30 Office Visit Copayment
Outpatient Prescription Drug Benefit[10] (Copayment applies per Prescription Unit or up to 30 days)	
Generic Formulary	$15 Copayment
Brand-Name Formulary	$35 Copayment
Non-Formulary	$50 Copayment
Prescription Drug Deductible (Per member per Calendar Year)	$150 for Brand-Name drugs (Applies to retail and mail service)
Oral Surgery Services[5]	$250 Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	$250 Copayment
Preventive Care Services[8,9] (Services as recommended by the American Academy of Pediatrics (AAP) including the Bright Futures Recommendations for pediatric preventive health care, the U.S. Preventive Services Task Force with an “A” or “B” recommended rating, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration (HRSA), and HRSA-supported preventive care guidelines for women, and as authorized by your Primary Care Physician in your Participating Medical Group.) Covered Services will include, but are not limited to, the following: • Colorectal Screening • Hearing Screening • Human Immunodeficiency Virus (HIV) Screening • Immunizations • Newborn Testing • Prostate Screening • Vision Screening • Well-Baby/Child/Adolescent Care • Well-Woman, including routine prenatal obstetrical office visits Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form.	Paid in full
Physician Care	
PCP Office Visit	$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	$30 Office Visit Copayment
Prosthetics and Corrective Appliances[5]	$50 Copayment per item

Benefits Available on an Outpatient Basis (Continued)

Radiation Therapy[5]	
Standard: (Photon beam radiation therapy)	Paid in full
Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; Gamma Knife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any)	$100 Copayment
Radiology Services[5]	
Standard:	Paid in full
Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media) A separate Copayment will be charged for each part of the body scanned as part of an imaging procedure.	$100 Copayment
Specialized Footwear for Foot Disfigurement[5]	Paid in full
Vision Refractions	
PCP Office Visit	$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	$30 Office Visit Copayment

Note: Benefits with Percentage Copayment amounts are based upon the UnitedHealthcare negotiated rate.

[1]Annual Copayment Maximum does not include Copayments for pharmacy and supplemental benefits, except Behavioral Health Supplemental Benefits.

[2]Copayments for audiologist and podiatrist visits will be the same as for the PCP.

[3]Cancer Clinical Trial services require preauthorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by a Non-Participating Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

[4]The inpatient hospital benefits Copayment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the *Combined Evidence of Coverage and Disclosure Form* for more details.

[5]In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate. (This footnote only applies to dollar copayments.)

[6]When an individual member meets the Annual Copayment Maximum no further copayments are required for the year for that individual.

[7] Bone anchored hearing aid will be subject to applicable medical/surgical categories (.e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Limited to one (1) bone anchored hearing aid during the entire period of time the Member is enrolled in the Health Plan (per lifetime). Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.

[8]Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate copayment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your Health Plan ID card.

[9]FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Copayment applies to contraceptive methods and procedures that are **NOT** defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.

[10]Refer to your Supplement to the Combined Evidence of Coverage and Disclosure Form and Pharmacy Schedule of Benefits for Outpatient Prescription Drug Coverage details.

[11]Procedures consistent with established medical practices in the treatment of infertility are covered when authorized by the member's Primary Care Physician, including diagnosis, diagnostic tests, medication and surgery. Gamete Intrafallopian Transfer (GIFT) services are covered when authorized by UnitedHealthcare's medical Director. GIFT benefits are limited to three (3) cycles during a member's lifetime when Medically Necessary. A cycle is defined as drug-induced ovulation and monitoring of hormonal levels with or without ova retrieval. Infertility is defined as either: (1) the presence of a demonstrated condition recognized by a participating Medical Group as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception. Refer to your *Combined Evidence of Coverage and Disclosure Form* for additional information on exclusions and limitations.

EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY OR AN URGENTLY NEEDED SERVICE (OUTSIDE GEOGRAPHIC AREA SERVED BY YOUR PARTICIPATING MEDICAL GROUP), EACH OF THE ABOVE-NOTED BENEFITS IS COVERED WHEN AUTHORIZED BY YOUR PARTICIPATING MEDICAL GROUP OR UNITEDHEALTHCARE. A UTILIZATION REVIEW COMMITTEE MAY REVIEW THE REQUEST FOR SERVICES.

Note: This is not a contract. This is a Schedule of Benefits and its enclosures constitute only a summary of the Health Plan.

The Medical and Hospital Group Subscriber Agreement and the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form and additional benefit materials must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract will be furnished upon request and is available at the UnitedHealthcare office and your employer's personnel office. UnitedHealthcare's most recent audited financial information is also available upon request.

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.uhcwest.com

PCA603016-000
NICE Plan Code: 92I
PRIME Plan Code: CH-2