UnitedHealthcare®

UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

HMO Schedule of Benefits

20/0%

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[1,5]	Individual $1,500 Family $3,000
PCP Office Visits	$20 Office Visit Copayment
Specialist Office Visits[2] (Member required to obtain referral to Specialist except for OB/GYN Physician Services and Emergency/Urgently Needed Services)	$20 Office Visit Copayment
Hospital Benefits	No charge
Emergency Services (Copayment waived if admitted)	$150 Copayment
Urgently Needed Services	
Urgent care services – services provided **within** the geographic area served by your medical group	$20 Copayment
Urgent care services – services provided **outside** of the geographic area served by your medical group	$75 Copayment
Please consult your EOC for additional details. Consult your physician website or office for available urgent care facilities within the area served by your medical group.	

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	No charge
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)	No charge
Hospital Benefits	No charge
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	No charge
Maternity Care[7]	No charge
Mental Health Services including, but not limited to, Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.)**	No charge

Benefits Available While Hospitalized as an Inpatient (Continued)

Newborn Care 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.	No charge
Physician Care	No charge
Reconstructive Surgery	No charge
Rehabilitation Care (Including physical, occupational and speech therapy)	No charge
Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child Inpatient and Residential Treatment Unlimited days **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	No charge
Skilled Nursing Facility Care (Up to 100 days per benefit period)	No charge
Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	No charge
Termination of Pregnancy (Medical/medication and surgical)	$125 Copayment

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit	 $20 Office Visit Copayment $20 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
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)	$20 Copayment per item
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	$20 Copayment
Dialysis (Physician office visit Copayment may apply)	$20 Copayment per treatment
Durable Medical Equipment[4]	20% Copayment

Benefits Available on an Outpatient Basis (Continued)

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.)	20% Copayment
Family Planning (Non-Preventive Care)[8]	
Vasectomy	$50 Copayment
Depo-Provera Injection – (other than contraception)[8]	
PCP Office Visit	$20 Office Visit Copayment
Specialist Office Visit	$20 Office Visit Copayment
Depo-Provera Medication – (other than contraception)[8] (Limited to one Depo-Provera injection every 90 days.)	$35 Copayment
Termination of Pregnancy (Medical/medication and surgical)	$125 Copayment
Hearing Aid - Standard *$5,000* benefit maximum per calendar year Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years. (Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.)	20% Copayment
Hearing Aid – Bone Anchored[6] 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[2,7]	
PCP Office Visit	$20 Office Visit Copayment
Specialist Office Visit[2]	$20 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	$20 Copayment per visit
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Infertility Services	Not covered
Infusion Therapy[4] (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment.)	$150 Copayment
Injectable Drugs[4,8] (Copayment/Coinsurance not applicable to injectable immunizations, birth control, infertility and insulin. If injectable drugs are administered in a physician's office, office visit Copayment/Coinsurance may also apply)	
Outpatient Injectable Medication	30% up to $150 Copayment per medication
Self-Injectable Medication	30% up to $150 Copayment per medication
Laboratory Services (When available through or authorized by your Participating Medical Group. Additional Copayment for office visits may apply)	No charge
Maternity Care, Tests and Procedures[7]	
PCP Office Visit	No charge
Specialist Office Visit	No charge

Benefits Available on an Outpatient Basis (Continued)

Mental Health Services (including Severe Mental Illness and Serious Emotional Disturbances of Child) Outpatient Office Visits include: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/ group counseling, individual/ group evaluations and treatment, referral services, and medication management	$20 Office Visit Copayment
All Other Outpatient Treatment include: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, electro-convulsive therapy, psychological testing , facility charges for day treatment centers, Behavioral Health Treatment for pervasive developmental Disorder or Autism Spectrum Disorders, laboratory charges, or other medical Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment, and psychiatric observation **(Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**)	No charge
Oral Surgery Services[4]	No charge
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$20 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	No charge
Physician Care PCP Office Visit Specialist Office Visit	 $20 Office Visit Copayment $20 Office Visit Copayment
Preventive Care Services[7,8] (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.	No charge

Benefits Available on an Outpatient Basis (Continued)

Prosthetics and Corrective Appliances[4]	20% Copayment
Radiation Therapy[4] Standard: (Photon beam radiation therapy) 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)	 No charge $50 Copayment
Radiology Services[4] Standard: (Additional Copayment for office visits may apply) 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.	 No charge $100 Copayment
Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED) **Please see outpatient "Mental Health Services" section for cost sharing and services that apply to SMI and SED. Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**.	
Substance Related and Addictive Disorder Outpatient Office Visits include, but are not limited to: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/group evaluations and treatment, individual/group counseling and detoxifications, referral services, and medication management All Other Outpatient Treatment includes, but are not limited to: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, facility charges for day treatment centers, laboratory charges. and methadone maintenance treatment **Please refer to your the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	 No charge No charge
Virtual Visits Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling Customer Service at the telephone number on your ID card.	$20 Copayment
Vision Refractions	$20 Office Visit Copayment

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

[1] Annual Copayment Maximum includes Copayments for UnitedHealthcare benefits including behavioral health and prescription drugs. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups.

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

[3] 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] 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.)

[5] Copayments for certain types of Covered Services do not apply toward the Out-of-Pocket Maximum and will require a Copayment even after the Out-of-Pocket Maximum has been met. The Annual Out-of-Pocket Maximum includes Copayments for UnitedHealthcare benefits including behavioral health and prescription drug benefits. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. When an individual member of a family unit has paid an amount of Deductible and Copayments for the Calendar Year equal to the Individual Out-of-Pocket Maximum, no further Copayments will be due for Covered Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Copayment until a member satisfies the Individual Out-of-Pocket Maximum or until a family satisfies the Individual Out-of-Pocket Maximum.

[6] 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. 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.

[7] 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.

[8] 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.

EACH OF THE ABOVE-NOTED BENEFITS IS COVERED WHEN AUTHORIZED BY YOUR PARTICIPATING MEDICAL GROUP OR UNITEDHEALTHCARE, EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY OR URGENTLY NEEDED SERVICE. 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.

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