UnitedHealthcare SignatureValue™ Advantage Offered by UnitedHealthcare of California

HMO - 40 (40/250A/500ded)

EFFECTIVE JULY 1, 2017

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

General Features

Calendar Year Deductible[1] All individual Deductible amounts will count toward the family Deductible, but an individual will not have to pay more than the individual Deductible amount.	Individual $500 Family $1000
Maximum Benefits	Unlimited
Annual Out-of-Pocket Maximum[2] All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount.	Individual $1,500 Family $4,500
PCP Office Visits	$40 Office Visit Copayment
Specialist Office Visits[3] (Member required to obtain referrals to Specialists except for OB/GYN Physician Services and Emergency/Urgently Needed Services)	$40 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)	$250 Copayment per admit after Deductible
Emergency Services (Copayment waived if admitted)	$100 Copayment
Urgently Needed Services Urgent care services **within** your personal physician service area Urgent care services **outside** your personal physician service area 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.	 $40 Copayment $40 Copayment

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	$250 Copayment per admit after Deductible
Clinical Trials[4]	Paid at negotiated rate after Deductible Balance (if any) is the responsibility of the Member
Hospice Services (Unlimited)	$250 Copayment per admit after Deductible
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)" under Inpatient Hospital Benefits.	$250 Copayment per admit after Deductible

Benefits Available While Hospitalized as an Inpatient (Continued)

Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	$250 Copayment per admit after Deductible
Maternity Care[7]	$250 Copayment per admit after Deductible
Mental Health Services including, but not limited to, Residential Treatment Centers	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
Newborn Care (The newborn care deductible and/or Copayment does not apply 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.)	$250 Copayment per admit after Deductible
Physician Care	No Charge
Reconstructive Surgery	$250 Copayment per admit after Deductible
Rehabilitation Care (Including physical, occupational and speech therapy)	$250 Copayment per admit after Deductible
Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child Inpatient and Residential Treatment Unlimited days	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
Skilled Nursing Facility Care (Up to 100 consecutive calendar days from the first treatment per disability)	No Charge
Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
Termination of Pregnancy (Medical/medication and surgical)	$125 Copayment after Deductible

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit[3]	 No charge No charge
Ambulance	No charge
Clinical Trials[4]	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/habilitation therapy may apply.)	No charge
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	No charge
Dialysis (Physician office visit Copayment may apply)	No charge
Durable Medical Equipment[5]	No charge
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.)	No charge

Benefits Available on an Outpatient Basis (Continued)

Family Planning (Non-Preventive Care)[8]	
Vasectomy	$50 Copayment
Depo-Provera Injection – (other than contraception)[8]	
PCP Office Visit	$40 Office Visit Copayment
Specialist Office Visit[3]	$40 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 Limited to one hearing aid (including repair/replacement) per hearing-impaired ear every three years.	No charge
Hearing Aid – Bone-Anchored[6] Repairs and/or replacements 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[3,7]	
PCP Office Visit	$40 Office Visit Copayment
Specialist Office Visit[3]	$40 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	No charge
Hospice Services (Unlimited)	No charge
Infertility Services	Not Covered
Infusion Therapy[5] (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit copayment.)	No charge
Injectable Drugs[5,8] (Copayment/coinsurance not applicable to injectable immunizations, birth control, infertility and insulin.)	
Outpatient Injectable Medication	$50 Copayment per medication
Self-Injectable Medication	$50 Copayment per medication
Laboratory Services (When available through and 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
Mental Health Services	
Outpatient Office Visits include: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, referral services, and medication management	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
All Other Outpatient Treatment include: Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, outpatient surgery, 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	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020

Benefits Available on an Outpatient Basis (Continued)

Oral Surgery Services[5]	No charge
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	No charge
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	$250 Copayment per admit after Deductible
Physician Care	
PCP Office Visit	$40 Office Visit Copayment
Specialist Office Visit[3]	$40 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 • Well-Woman, including routine prenatal obstetrical office visits Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form.	No charge
Prosthetics and Corrective Appliances[5]	No charge
Radiation Therapy[5]	
Standard: (Photon beam radiation therapy)	No charge
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.)	$40 Copayment
Radiology Services[5]	
Standard: (Additional Copayment for office visits may apply)	No charge
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.	$40 Copayment

Benefits Available on an Outpatient Basis (Continued)

Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
Substance Related and Addictive Disorder	
Outpatient Office Visits include, but are not limited to: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, referral services, and medication management	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
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	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
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 calling Customer Service at the telephone number on your ID card or visit one of our designated virtual visit providers: AmWell; amwell.com; or Doctor on Demand: doctorondemand.com	$25 Copayment
Vision Refractions	$40 Office Visit Copayment

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

[1]Certain Covered Services will not be covered until you meet the Calendar Year Deductible. Only amounts incurred for Covered Services that are subject to the Deductible will count toward the Deductible. The Deductible applies to the Annual Out-of-Pocket Maximum. The amounts applied to the Deductible are based upon UnitedHealthcare's contracted rates.

[2]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 drugs benefits. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups.

[3]Copayments for Audiologist and Podiatrist visits will be the same as for the PCP.

[4]Clinical Trial Services require preauthorization by UnitedHealthcare. If you participate in a 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 Provider's billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable copayments, coinsurance or deductibles.

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

[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. Replacement of external hearing aid components are covered under the Durable Medical Equipment benefit. 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 ARE COVERED WHEN RENDERED OR AUTHORIZED BY YOUR PARTICIPATING MEDICAL GROUP OR UNITEDHEALTHCARE, EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY OR AN 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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