UnitedHealthcare®

# UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

## Performance HMO Schedule of Benefits (Benefit Package A, Network 3) 40-60/20%

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

### General Features

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| Calendar Year Deductible | None |
| Maximum Benefits | Unlimited |
| Annual Out-of-Pocket Limit<br>Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health and prescription drug. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups.<br>Co-payments for certain types of Covered Health Care Services do not apply toward the Out-of-Pocket Limit and will require a Co-payment even after the Out-of-Pocket Limit has been met. The Annual Out-of-Pocket Limit includes Co-payments 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 Co-payments for the Calendar Year equal to the Individual Out-of-Pocket Limit, no further Co-payments will be due for Covered Health Care Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Co-payment until a member satisfies the Individual Out-of-Pocket Limit or until a family satisfies the Family Out-of-Pocket Limit. | Individual $5,000<br>Family $10,000 |
| PCP Office Visits | $40 Office Visit Co-payment |
| Specialist Office Visits<br>(Member required to obtain referral to Specialists except for OB/GYN Physician Services and Emergency/Urgently Needed Services) Co-payments for audiologist and podiatrist visits will be the same as for the PCP. | $60 Office Visit Co-payment |
| Hospital Benefits | 20% Co-payment |
| Emergency Services<br>(Copayment waived if admitted) | $300 Co-payment |
| Urgently Needed Services | |
| Urgent care services – services provided **within** the area served by your medical group | $40 Co-payment |
| Urgent care services – services provided **outside** of the area served by your medical group | $50 Co-payment |
| 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

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| Bone Marrow Transplants | 20% Co-payment |
| Clinical Trials<br>Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network 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 Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles. | Paid at negotiated rate<br>Balance (if any) is the responsibility of the Member |
| Hospice Services<br>(Prognosis of life expectancy of one year or less) | 20% Co-payment |
| Hospital Benefits | 20% Co-payment |
| Mastectomy/Breast Reconstruction<br>(After mastectomy and complications from mastectomy) | 20% Co-payment |
| Maternity Care<br>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 Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card. | 20% Co-payment |
| Mental Health Services including, but not limited to, Residential Treatment Centers<br>**Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.)** | 20% Co-payment |
| Newborn Care<br>The inpatient hospital benefits Co-payment 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. | 20% Co-payment |
| Physician Care | No charge |
| Reconstructive Surgery | 20% Co-payment |
| Rehabilitation Care<br>(Including physical, occupational and speech therapy) | 20% Co-payment |
| Severe Mental Illness Benefit and<br>Serious Emotional Disturbances of a Child<br>Inpatient and Residential Treatment<br>Unlimited days<br>**Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage**. | 20% Co-payment |
| Skilled Nursing Facility Care<br>(Up to 100 days per benefit period) | No Charge |
| Substance Related and Addictive Disorder including, but not limited to,<br>Inpatient Medical Detoxification and Residential Treatment Centers<br>**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<br>(Medical/medication and surgical) | $50 Co-payment |

## Benefits Available on an Outpatient Basis

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| Allergy Testing/Treatment<br>(Serum is covered)<br>PCP Office Visit<br>Specialist Office Visit | <br><br>$40 Office Visit Co-payment<br>$60 Office Visit Co-payment |
| Ambulance | No charge |
| Clinical Trials<br>Clinical Trial services require prior authorization by UnitedHealthcare. If you participate in a Cancer Clinical Trial provided by an Out-of-Network 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 Out-of-Network Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Co-payments, coinsurance or deductibles. | Paid at negotiated rate<br>Balance (if any) is the responsibility of the Member |
| Cochlear Implant Devices<br>(Additional Co-payment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)<br>In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate. | No charge |
| Dental Treatment Anesthesia<br>(Additional Copayment for outpatient surgery or inpatient hospital benefits may apply) | $40 Co-payment |
| Dialysis<br>(Physician office visit Copayment may apply) | $40 Co-payment per treatment |
| Durable Medical Equipment | No charge |
| Durable Medical Equipment for the Treatment of Pediatric Asthma<br>(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 |
| Family Planning (Non-Preventive Care)<br>Vasectomy<br><br>Depo-Provera Injection – (other than contraception)<br>PCP Office Visit<br>Specialist Office Visit<br>Depo-Provera Medication – (other than contraception)<br>(Limited to one Depo-Provera injection every 90 days.)<br>Termination of Pregnancy<br>(Medical/medication and surgical)<br>FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Co-payment applies to contraceptive methods and procedures that are **NOT** defined as Covered Health Care Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form. | <br>Co-payment will be the applicable Physician office visit, Outpatient Surgery or Inpatient Surgery<br><br><br>$40 Office Visit Copayment<br>$60 Office Visit Copayment<br>$35 Co-payment<br><br>$50 Co-payment |
| Hearing Aid - Standard<br>$5,000 annual 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.) | No charge |

## Benefits Available on an Outpatient Basis (Continued)

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| Hearing Aid - Bone Anchored<br>Repairs and/or replacement are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.<br>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..<br>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. | 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<br>PCP Office Visit<br>Specialist Office Visit<br>Co-payments for audiologist and podiatrist visits will be the same as for the PCP.<br>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 Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card. | No charge |
| Home Health Care Visits | No charge |
| Hospice Services<br>(Prognosis of life expectancy of one year or less) | No charge |
| Infertility Services | Not covered |
| Infusion Therapy<br>(Infusion Therapy is a separate Co-payment in addition to an office visit Co-payment.)<br>In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate. | No charge |
| Injectable Drugs [5,9]<br>(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)<br>Outpatient Injectable Medication<br>Self-Injectable Medication | <br><br><br><br><br><br>No charge<br>No charge |
| Laboratory Services<br>(When available through or authorized by your Participating Medical Group. Additional Copayment for office visits may apply.) | No charge |
| Maternity Care, Tests and Procedures<br>PCP Office Visit<br>Specialist Office Visit<br>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 Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card. | <br>No charge<br>No charge |

## Benefits Available on an Outpatient Basis (Continued)

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| Mental Health Services (including Severe Mental Illness and Serious Emotional Disturbances of a Child)<br>Outpatient Office Visits include:<br>Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/ group counseling, individual/ group evaluations and treatment, referral services, and medication management<br>All Other Outpatient Treatment include:<br>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<br>**(Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**) | $40 Office Visit Co-payment<br><br><br><br><br><br>No charge |
| Oral Surgery Services<br>In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate. | $40 Office Visit Co-payment |
| Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility<br>(Including physical, occupational and speech therapy) | $40 Office Visit Co-payment |
| Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility | $500 Co-payment per admit |
| Physician Care<br>PCP Office Visit<br>Specialist Office Visit | <br>$40 Office Visit Co-payment<br>$60 Office Visit Co-payment |
| Preventive Care Services<br>(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 Health Care Services will include, but are not limited to, the following:<br>• Colorectal Screening<br>• Hearing Screening<br>• Human Immunodeficiency Virus (HIV) Screening<br>• Immunizations<br>• Newborn Testing<br>• Prostate Screening<br>• Vision Screening<br>• Well-Baby/Child/Adolescent care<br>• Well-Woman, including routine prenatal obstetrical office visits<br>Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form.<br>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 Co-payment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your ID card. | No charge |
| Prosthetics and Corrective Appliances | No charge |

## Benefits Available on an Outpatient Basis (Continued)

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| Radiation Therapy | |
| Standard:<br>(Photon beam radiation therapy) | No charge |
| Complex:<br>(Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Co-payment 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 Co-payment amount if any)<br>In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate. | No charge |
| Radiology Services | |
| Standard:<br>(Additional Co-payment for office visits may apply) | No charge |
| Specialized Scanning and Imaging Procedures:<br>(Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media)<br>A separate Co-payment will be charged for each part of the body scanned as part of an imaging procedure.<br>In instances where the negotiated rate is less than your Co-payment, you will pay only the negotiated rate. | $200 Co-payment |
| Severe Mental Illness (SMI) and<br>Serious Emotional Disturbances of a Child (SED)<br>**Please see outpatient "Mental Health Services" section for cost sharing and services that apply to SMI and SED.**<br>**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:<br>Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, individual/group evaluations and treatment, individual/group counseling and detoxifications, referral services, and medication management | No charge |
| All Other Outpatient Treatment includes, but are not limited to:<br>Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis intervention, facility charges for day treatment centers, laboratory charges. and methadone maintenance treatment<br>**Please refer to your the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.** | No charge |
| Virtual Visits<br>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. | $25 Co-payment |
| Vision Refractions | No charge |

**Note: Benefits with Percentage Co-payment amounts are based upon the UnitedHealthcare negotiated rate.**

**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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