UnitedHealthcare®

UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

HMO Deductible Schedule of Benefits

SILVER SIGNATURE 2250

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

General Features

Calendar Year Deductible 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 Limit. The amounts applied to the Deductible are based upon UnitedHealthcare's contracted rates. The Family Deductible is an embedded deductible. When an individual member of a family unit satisfies the Individual Deductible for the Calendar Year, no further Deductible will be required for that individual member for the remainder of the Calendar Year. The remaining family members will continue to pay full member charges for services that are subject to the deductible until the member satisfies the Individual Deductible or until the family, as a whole, meets the Family Deductible.	$2,250/individual $4,500/family
Maximum Benefits	Unlimited
Annual Out-of-Pocket Limit Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including pediatric vision, pediatric dental, behavioral health, prescription drug, chiropractic, and acupuncture benefits. It does not include standalone, separate and independent Dental and Vision benefit plans or infertility benefit, if purchased by the employer group. When an individual member of a family unit satisfies the individual out of pocket limit for the calendar year, no further out of pocket limit will be required for that individual member for the remainder of the calendar year. The remaining family members will continue to pay charges until a member or the family as a whole meets the family out of pocket limit.	$7,350/individual $14,700/family
PCP/ Other Practitioner Office Visits	$50 Office Visit Co-payment
Specialist (Member required to obtain referral to specialist, except for OB/GYN Physician services and Emergency/Urgently Needed Services)	$75 Office Visit Co-payment
Hospital Benefits	40% Co-payment after Deductible
Emergency Services	40% Co-payment after Deductible
Urgently Needed Services Urgent care services – services provided **within** the geographic area served by your medical group Urgent care services – services provided **outside** of the geographic area served by your medical group Please consult your EOC for additional details. Consult your physician website or office for available urgent care facilities within the geographic area served by your medical group.	 $50 Office Visit Co-payment $100 Co-payment

Benefits Available While Hospitalized as an Inpatient (Continued)

Bone Marrow Transplants	40% Co-payment after Deductible
Clinical Trials Clinical Trial services require preauthorization 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 Network 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 Network Providers, in addition to any applicable Co-payments or deductibles.	Paid at negotiated rate after Deductible Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	40% Co-payment after Deductible
Hospital Benefits	40% Co-payment after Deductible
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	40% Co-payment after Deductible
Maternity Care 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 No charge. There may be a separate co-payment for the office visit and other additional charges for services rendered. Please call the number on your Health Plan ID card.	40% Co-payment after Deductible
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.**	40% Co-payment after Deductible
Newborn Care 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.	40% Co-payment after Deductible
Physician Care	40% Co-payment
Reconstructive Surgery	40% Co-payment after Deductible
Rehabilitation and Habilitation Care (Including physical, occupational and speech therapy)	40% Co-payment after Deductible
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**	40% Co-payment after Deductible
Skilled Nursing Facility Care (Up to 100 days per benefit period)	40% Co-payment after Deductible
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.**	40% Co-payment after Deductible
Termination of Pregnancy (Medical/medication and surgical)	40% Co-payment after Deductible

Benefits Available on an Outpatient Basis

Acupuncture **Please refer to your Acupuncture Supplement to the Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	$10 Co-payment
Allergy Testing/Treatment (Serum is covered)	
PCP Office Visit	$50 Office Visit Co-payment
Specialist	$75 Office Visit Co-payment
Ambulance (Only one ambulance Co-payment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Co-payment)	$100 Co-payment
Chiropractic Care (20-visit maximum per calendar year) **Please refer to your Chiropractic Supplement to the Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	$15 Co-payment
Clinical Trials Clinical Trial services require preauthorization 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 Network 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 Network Providers, in addition to any applicable Co-payments or deductibles.	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices (Additional Co-payment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation/habilitation therapy may apply.) Co-payment shall never exceed the plan's actual cost of the service.	$50 Co-payment per item
Dental Treatment Anesthesia (Additional Co-payment for outpatient surgery or inpatient hospital benefits may apply. Please refer to your Dental Supplement to the Combined Evidence of Coverage and Disclosure Form for pediatric dental benefits.)	$50 Co-payment
Dialysis (Physician office visit Co-payment may apply)	$50 Co-payment per treatment
Durable Medical Equipment Co-payment shall never exceed the plan's actual cost of the service.	$50 Co-payment 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 who are covered until at least the end of the month in which Member turns 19 years of age.)	No charge
Family Planning (Non-Preventive Care) 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 Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.	
Vasectomy	$50 Co-payment
Depo-Provera Injection – (other than contraception)	
PCP/ Practitioner Office Visit	$50 Office Visit Co-payment
Specialist	$75 Office Visit Co-payment
Depo-Provera Medication – (other than contraception) (Limited to one Depo-Provera injection every 90 days.)	$35 Co-payment
Termination of Pregnancy (Medical/medication and surgical)	40% Co-payment after Deductible

Benefits Available on an Outpatient Basis (Continued)

Hearing Aid – Standard ($2,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair/replacement) per hearing-impaired ear every three years.)	$50 Co-payment
Hearing Aid – Bone-Anchored (Repairs and/or replacement are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.) 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.	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	
PCP Office Visit/ Nonphysician Health Care Practitioner Office Visit	$50 Office Visit Co-payment
Specialist	$75 Office Visit Co-payment
Home Health Care Visits Home Health visits up to a maximum of 100 visits per year for services other than rehabilitation or habilitation. Home Health visits for rehabilitation up to a maximum of 100 visits per year. Home Health visits for habilitation up to a maximum of 100 visits per year. For covered rehabilitation and habilitative services other than home health visits, please refer to “Outpatient Habilitative Services and Outpatient Therapy″ and "Outpatient Rehabilitation and Outpatient Therapy" in this schedule. For Infusion Therapy, a separate Infusion Therapy Copayment applies per 30 days.	$50 Co-payment per visit
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Infertility Services (If purchased by your employer, please refer to your Infertility Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)	Not covered
Infusion Therapy (Infusion Therapy is a separate Co-payment in addition to an office visit co-payment.) Co-payment shall never exceed the plan’s actual cost of the service.	$150 Co-payment per medication
Injectable Drugs (Co-payment not applicable to injectable immunizations, birth control, Infertility and insulin. If injectable drugs are administered in a physician’s office, office visit Co-payment may also apply.) 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 Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form. Co-payment shall never exceed the plan’s actual cost of the service.	
Outpatient Injectable Medication	$150 Co-payment per medication
Self-Injectable Medication	$150 Co-payment per medication
Laboratory Services (When available through or authorized by your Participating Medical Group. Additional Co-payment for office visits may apply.)	$40 Co-payment
Maternity Care, Tests and Procedures 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 No charge. There may be a separate co-payment for the office visit and other additional charges for services rendered. Please call the number on your Health Plan ID card.	
PCP Office Visit	No charge
Specialist	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	$50 Office Visit Co-payment
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 UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	No charge
Outpatient Habilitative Services and Outpatient Therapy	$50 Office Visit Co-payment
Oral Surgery Services	40% Co-payment after Deductible
Outpatient Prescription Drug Benefit Refer to your Supplement to the Combined Evidence of Coverage and Disclosure Form and Pharmacy Schedule of Benefits for Outpatient Prescription Drug Coverage details. (Co-payment applies per Prescription Unit or up to 30 days) Tier 1 Tier 2 Tier 3 Tier 4 Prescription Drug Deductible (Per member per Calendar Year) Co-payment Maximum of $200 for up to a 30 day supply of an orally administered anticancer medication regardless of a Prescription Drug Deductible and/or Medical Deductible.	$25 Co-payment $50 Co-payment after Deductible $100 Co-payment after Deductible 25% Co-payment after Deductible up to $250 per script $200/individual; $400/family Applies to Tiers 2, 3 and 4 (applies to retail and mail service)
Outpatient Rehabilitation Services and Outpatient Therapy	$50 Office Visit Co-payment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility Outpatient Surgery Physician Care	40% Co-payment after Deductible 40% Co-payment
Pediatric Dental Services **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.**	See your Supplement to the UnitedHealthcare of California for pediatric dental benefits.
Pediatric Vision Services **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.**	See your Supplement to the UnitedHealthcare of California for pediatric vision benefits.
Physician Care PCP Office Visit/ Nonphysician Health Care Practitioner Office Visit Specialist	 $50 Office Visit Co-payment $75 Office Visit Co-payment

Benefits Available on an Outpatient Basis (Continued)

Preventive Care Services 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 No charge. There may be a separate co-payment for the office visit and other additional charges for services rendered. Please call the number on your Health Plan ID card. 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 Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form. (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
Prosthetics and Corrective Appliances Co-payment shall never exceed the plan’s actual cost of the service.	$50 Co-payment per item
Radiation Therapy Standard: (Photon beam radiation therapy) Complex: (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.) Co-payment shall never exceed the plan’s actual cost of the service.	 No charge $200 Co-payment
Radiology Services Standard: (Additional Co-payment for office visits may apply) Co-payment shall never exceed the plan’s actual cost of the service. 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 Co-payment will be charged for each part of the body scanned as part of an imaging procedure. Co-payment shall never exceed the plan’s actual cost of the service.	 $40 Co-payment $200 Co-payment

Benefits Available on an Outpatient Basis (Continued)

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.**	
Specialized Footwear for Foot Disfigurement Co-payment shall never exceed the plan's actual cost of the service.	$50 Co-payment per item
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	$50 Office Visit Co-payment
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 UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	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 the telephone number on your ID card.	$5 Co-payment
Vision Refractions (For pediatric vision, please refer to your Vision Services Supplement to the Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)	$30 Office Visit Co-payment

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 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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