UnitedHealthcare SignatureValue™ Advantage Offered by UnitedHealthcare of California

HMO – 40 (40/250A/500ded)

EFFECTIVE JULY 1, 2016

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

General Features

Calendar Year Deductible[1]	Individual $500 Family $1000
Maximum Benefits	Unlimited
Annual Out-of-Pocket Maximum[2]	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 (Medically Necessary Services required outside geographic area served by your Participating Medical Group. Please consult your Combined Evidence of Coverage and Disclosure Form for additional details. Copayment waived if admitted.)	$40 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits.

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)	$250 Copayment per admit after Deductible
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	$250 Copayment per admit after Deductible
Maternity Care[7]	$250 Copayment per admit after Deductible

Benefits Available While Hospitalized as an Inpatient (Continued)

Mental Health Services	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	Paid in full
Reconstructive Surgery	$250 Copayment per admit after Deductible
Rehabilitation Care (Including physical, occupational and speech therapy)	$250 Copayment per admit after Deductible
Skilled Nursing Facility Care (Up to 100 consecutive calendar days from the first treatment per disability)	Paid in full
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	Paid in full
Specialist Office Visit[3]	Paid in full
Ambulance	Paid in full
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 therapy may apply.)	Paid in full
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	Paid in full
Dialysis (Physician office visit Copayment may apply)	Paid in full
Durable Medical Equipment[5]	Paid in full
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.)	Paid in full
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

Benefits Available on an Outpatient Basis (Continued)

Hearing Aid – Standard (Limited to one hearing aid (including repair/replacement) per hearing-impaired ear every three years.)	Paid in full
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 Specialist Office Visit[3]	 $40 Office Visit Copayment $40 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	Paid in full
Hospice Services	Paid in full
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. Copayment applies per 30 days or treatment plan, whichever is shorter.)	Paid in full
Injectable Drugs[5,8] Outpatient Injectable Medications Self-Injectable Medications (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.)	$50 Copayment per visit
Laboratory Services (When available through and authorized by your Participating Medical Group. Additional Copayment for office visits may apply)	Paid in full
Maternity Care, Tests and Procedures[7] PCP Office Visit Specialist Office Visit	 Paid in full Paid in full
Mental Health Services	Coverage provided by MHN Customer Service Phone Number: (888) 327-0020
Oral Surgery Services[5]	Paid in full
Outpatient Medical Rehabilitation Therapy at a participating free-standing or outpatient facility (Including physical, occupational and speech therapy)	Paid in full
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	$250 Copayment per admit after Deductible
Physician Care PCP Office Visit Specialist Office Visit[3]	 $40 Office Visit Copayment $40 Office Visit Copayment

Benefits Available on an Outpatient Basis (Continued)

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.	Paid in full
Prosthetics and Corrective Appliances[5]	Paid in full
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.)	$40 Copayment
Radiology Services[5] Standard (Additional Copayment for office visits may apply):	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.	$40 Copayment
Vision Refractions	
PCP Office Visit	$40 Office Visit Copayment
Specialist Office Visit[3]	$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.
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]The Annual Out-of-Pocket Maximum includes Copayments for UnitedHealthcare 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 the member satisfies the Individual Out-of-Pocket Maximum or until the family, as a whole, meets the Family Out-of-Pocket Maximum.

[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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