UnitedHealthcare®

UnitedHealthcare SignatureValue™ Alliance Offered by UnitedHealthcare of California

HMO Deductible Schedule of Benefits
HRA-QUALIFIED DEDUCTIBLE HEALTH PLAN
35-50/20%/2000DED

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

General Features

Calendar Year Deductible[1] For the Family Deductible, if an individual member meets the Individual deductible amount, his/ her deductible is met, and the remaining Family deductible must be met by one or more of the family members.	Individual $2,000 Family $2,000
Maximum Benefits	Unlimited
Annual Out-of-Pocket Maximum[2] For the Family Out-of-Pocket Maximum, if an individual member meets the Individual out of pocket amount, his/ her out of pocket is met and the remaining Family out of pocket must be met by one or more of the family members.	Individual $3,000 Family $6,000
PCP Office Visits	$35 Copayment
Specialist Office Visits[3] (Member required to obtain referrals to Specialists except for OB/GYN Physician Services and Emergency/Urgently Needed Services)	$50 Copayment
Hospital Benefits	20% Copayment after Deductible
Emergency Services (Copayment waived if admitted)	20% Copayment after Deductible
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.	 $35 Copayment 20% Copayment after Deductible

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	20% Copayment after Deductible
Clinical Trials[4]	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)	20% Copayment after Deductible
Hospital Benefits	20% Copayment after Deductible
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	20% Copayment after Deductible
Maternity Care[7]	20% Copayment after Deductible

Benefits Available While Hospitalized as an Inpatient (Continued)

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 description of this coverage.)**	20% Copayment after Deductible
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.)	20% Copayment after Deductible
Physician Care	20% Copayment after Deductible
Reconstructive Surgery	20% Copayment after Deductible
Rehabilitation Care (Including physical, occupational and speech therapy)	20% Copayment 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 description of this coverage**.	20% Copayment after Deductible
Skilled Nursing Facility Care (Up to 100 days per benefit period)	20% Copayment 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 description of this coverage.**	No charge
Termination of Pregnancy (Medical/medication and surgical)	20% Copayment after Deductible

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit[3]	 $35 Copayment $50 Copayment
Ambulance	20% Copayment after Deductible
Clinical Trials[4]	Paid at negotiated rate after Deductible 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.)	20% Copayment after Deductible
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	20% Copayment after Deductible
Dialysis (Physician office visit Copayment may apply)	20% Copayment after Deductible
Durable Medical Equipment[5]	20% Copayment after Deductible

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 after Deductible
Family Planning (Non-Preventive Care)[8]	
Vasectomy	20% Copayment after Deductible
Depo-Provera Injection – (other than contraception)[8]	
PCP Office Visit	$35 Copayment
Specialist Office Visit[3]	$50 Copayment
Depo-Provera Medication – (other than contraception)[8] (Limited to one Depo-Provera injection every 90 days.)	20% Copayment after Deductible
Termination of Pregnancy (Medical/medication and surgical)	20% Copayment after Deductible
Hearing Aid – Standard $5,000 annual benefit maximum per calendar year. Limited to one hearing aid (including repair/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 after Deductible
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	$35 Copayment
Specialist Office Visit[3]	$50 Copayment
Home Health Care Visits	$35 Copayment per visit
Hospice Services (Prognosis of life expectancy of one year or less)	20% Copayment after Deductible
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.)	$250 Copayment
Injectable Drugs[5,8] (Copayment/coinsurance not applicable to injectable immunizations, birth control, infertility and insulin.)	
Outpatient Injectable Medication	30% up to $250 Copayment per medication
Self-Injectable Medication	30% up to $250 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	$35 Copayment
Specialist Office Visit	$35 Copayment

Benefits Available on an Outpatient Basis (Continued)

Mental Health Services Outpatient Office Visits include: Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures, referral services, and medication management	$40 Copayment
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 **(Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage)**	No charge after Deductible
Oral Surgery Services[5]	20% Copayment after Deductible
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$35 Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	20% Copayment after Deductible
Physician Care PCP Office Visit Specialist Office Visit[3]	 $35 Copayment $50 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

Benefits Available on an Outpatient Basis (Continued)

Prosthetics and Corrective Appliances[5]	20% Copayment after Deductible
Radiation Therapy[5]	
Standard: (Photon beam radiation therapy)	20% Copayment after Deductible
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.)	20% Copayment after Deductible
Radiology Services[5]	
Standard: (Additional Copayment for office visits may apply)	20% Copayment after Deductible
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.	20% Copayment after Deductible
Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage**.	$40 Copayment
Partial Hospitalization/ Day Treatment and Intensive Outpatient Treatment	No charge after Deductible
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	No charge
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 description of this coverage.**	No charge
Vision Refractions	$35 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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