Premium rates and/or product forms included herein are subject to approval by regulators. If the rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings, in accordance with applicable law.

UnitedHealthcare SignatureValue™ Alliance Offered by UnitedHealthcare of California

HMO Schedule of Benefits

UHC Silver 70 HMO 2000/45+Child Dental, Network 3 – Alliance

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 $2,000 Family $4,000
Maximum Benefits	Unlimited
Annual Out-of Pocket Maximum[2]	$6,800/individual $13,600/family
PCP/ Other Practitioner Office Visits	$45 Office Visit Copayment
Specialist (Member required to obtain referral to specialist, except for OB/GYN Physician services and Emergency/Urgently Needed Services)	$75 Office Visit Copayment
Hospital Benefits Facility fee (e.g. hospital room) Physician/surgeon fee	 20% Copayment after Deductible 20% Copayment after Deductible
Emergency Room (Copayment waived if admitted) Emergency Room Physician Services (Copayment waived if admitted)	$350 Copayment No charge
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.	 $45 Office Visit Copayment $45 Copayment

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	20% Copayment after Deductible
Clinical Trials[3]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Hospital Benefits	20% Copayment after Deductible
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	20% Copayment after Deductible
Maternity Care[6]	20% Copayment after Deductible

Benefits Available While Hospitalized as an Inpatient (Continued)

Mental Health Services including, but not limited to, Residential Treatment Centers	
Facility fee	20% Copayment after Deductible
Physician fee	20% Copayment after Deductible
Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.	
Newborn Care[4]	20% Copayment after Deductible
Physician Care	20% Copayment after Deductible
Reconstructive Surgery	20% Copayment after Deductible
Rehabilitation and Habilitation Care (Including physical, occupational and speech therapy)	20% Copayment after Deductible
Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child	20% Copayment after Deductible
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.	
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	
Facility fee	20% Copayment after Deductible
Physician fee	20% Copayment after Deductible
Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.	
Termination of Pregnancy (Medical/medication and surgical)	20% Copayment after Deductible

Benefits Available on an Outpatient Basis

Acupuncture	$45 Copayment
Please refer to your Acupuncture Supplement to the Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.	
Allergy Testing/Treatment (Serum is covered)	
PCP Office Visit	$45 Office Visit Copayment
Specialist	$75 Office Visit Copayment
Ambulance (Only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Copayment)	$250 Copayment after Deductible
Chiropractic Care	Not covered
Please refer to your Chiropractic Supplement to the Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage, if covered.	
Clinical Trials[3]	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)	20% Copayment
Dental Treatment Anesthesia (Additional Copayment 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.)	20% Copayment
Dialysis (Physician office visit Copayment may apply)	20% Copayment
Durable Medical Equipment[5]	20% Copayment
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
Family Planning (Non-Preventive Care)[7]	
Vasectomy	$50 Copayment
Depo-Provera Injection – (other than contraception)[8]	
PCP/ Practitioner Office Visit	$45 Office Visit Copayment
Specialist	$75 Office Visit Copayment
Depo-Provera Medication – (other than contraception)[7] (Limited to one Depo-Provera injection every 90 days.)	$35 Copayment
Termination of Pregnancy (Medical/medication and surgical)	20% Copayment
Home Health Care Visits Limited to a maximum of 100 visits per year. Visit limit does not apply to home health visits for rehabilitation and habilitation purposes. Rehabilitation visits limited to a max of 100 per year Habilitation visits limited to a max of 100 per year	20% Copayment
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[5] (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment.)	20% Copayment per medication

Benefits Available on an Outpatient Basis (Continued)

Injectable Drugs [4,7] (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.)	
Outpatient Injectable Medication	20% Copayment per medication
Self-Injectable Medication	20% Copayment per medication
Laboratory Services (When available through or authorized by your Participating Medical Group. Additional Copayment for office visits may apply.)	$40 Copayment
Maternity Care, Tests and Procedures[7]	
PCP Office Visit	No charge
Specialist	No charge
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 and treatment, individual/group evaluations, referral services, and medication management	$45 Office Visit Copayment
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 **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 – Outpatient Therapy	$45 Office Visit Copayment
Oral Surgery Services[5]	20% Copayment
Outpatient Prescription Drug Benefit[8] (Copayment applies per Prescription Unit or up to 30 days)	
Tier 1	$15 Copayment
Tier 2	$55 Copayment after Deductible
Tier 3	$85 Copayment after Deductible
Tier 4	20% Copayment after Deductible up to $250 per prescription after Deductible
Prescription Drug Deductible (Per member per Calendar Year)	$250/individual; $500/family For Tiers 2, 3 and 4 drugs (Applies to retail and mail service)
Coinsurance/ Copayment 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.	
Outpatient Rehabilitation Services – Outpatient Therapy	$45 Office Visit Copayment

Benefits Available on an Outpatient Basis (Continued)

Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	
Facility fee	20% Copayment
Physician/surgeon fees	20% Copayment
Outpatient visit	20% Copayment
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	$45 Office Visit Copayment
Specialist	$75 Office Visit Copayment
Preventive Care Services[6,7] (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[5]	20% Copayment
Radiation Therapy[5]	
Standard: (Photon beam radiation therapy)	20% Copayment
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

Benefits Available on an Outpatient Basis (Continued)

Radiology Services[5] Standard: (Additional Copayment for office visits may apply) 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.	 $70 Copayment 20% Copayment
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[5]	20% Copayment
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 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 to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	 $45 Office Visit Copayment 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 Customer Service at the telephone number on your ID card.	$25 Copayment

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

[1]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] Annual Out-of-Pocket Maximum includes Copayments for UnitedHealthcare benefits including pediatric vision, pediatric dental, behavioral health, prescription drug, 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 maximum for the calendar year, no further out of pocket maximum 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 maximum.

[3] Clinical Trial services require preauthorization by UnitedHealthcare. If you participate in a Cancer 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 Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

[4] The inpatient hospital benefits Copayment 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.

[5] Copayment shall never exceed the plan's actual cost of the service. For example, if laboratory costs less than $45 copayment, the lesser amount is the applicable cost sharing amount. (This footnote only applies to dollar copayments.)

[6]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 copayment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your Health Plan ID card.

[7]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.

[8]Refer to your Supplement to the Combined Evidence of Coverage and Disclosure Form and Pharmacy Schedule of Benefits for Outpatient Prescription Drug Coverage details.

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.

P.O. Box 30968
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Customer Service:
800-624-8822
711 (TTY)
www.myuhc.com

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