UnitedHealthcare®

PENDING REGULATORY APPROVAL

SignatureValue™ Alliance HMO Offered by UnitedHealthcare of California

SignatureValue Alliance HMO Platinum Schedule of Benefits
UHC Platinum 90 HMO 0/15 + Child Dental [INF]

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

General Features

Calendar Year Deductible	None
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 co-payments will be required for that individual member for the remainder of the calendar year. The remaining family members will continue to pay co-payments until a member satisfies the individual out-of-pocket limit or the family as a whole meets the family out of pocket limit.	$4,500/Individual $9,000/Family
PCP/Other Practitioner Office Visits	$15 Office Visit Co-payment
Specialist (Member required to obtain referral to Specialists, except for OB/GYN Physician Services and Emergency/Urgently Needed Services)	$30 Office Visit Co-payment
Hospital Benefits Facility fee (e.g. hospital room) Physician/surgeon fee	 10% Co-payment 10% Co-payment
Emergency Room (Co-payment waived if admitted) Emergency Room Physician Services (Co-payment waived if admitted)	$150 Co-payment 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.	 $15 Office Visit Co-payment $15 Co-payment

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	10% Co-payment
Clinical Trials 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 Network Providers, in addition to any applicable Co-payments or deductibles.	Paid at negotiated rate. Balance (if any) is the responsibility of the Member.

Benefits Available While Hospitalized as an Inpatient (Continued)

Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Hospital Benefits	10% Co-payment
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	10% Co-payment
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.	10% Co-payment
Mental Health Services including, but not limited to, Residential Treatment Centers Facility fee Physician fee **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.)**	 10% Co-payment 10% Co-payment
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.	10% Co-payment
Physician Care	10% Co-payment
Reconstructive Surgery	10% Co-payment
Rehabilitation and Habilitation Care (Including physical, occupational and speech therapy)	10% Co-payment
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**.	10% Co-payment
Skilled Nursing Facility Care (Up to 100 days per benefit period)	10% Co-payment
Substance Related and Addictive Disorder including, but not limited to, Inpatient Medical Detoxification and Residential Treatment Centers Facility fee Physician fee **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	 10% Co-payment 10% Co-payment
Termination of Pregnancy (Medical/medication and surgical)	10% Co-payment

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.**	$15 Co-payment
Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist	 $15 Office Visit Co-payment $30 Office Visit Co-payment
Ambulance – including emergency and non-emergency (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)	$150 Co-payment

Benefits Available on an Outpatient Basis (Continued)

Chiropractic Care **Please refer to your Chiropractic Supplement to the Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage, if covered.**	Not covered
Clinical Trials 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 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)	10% Co-payment
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.)	10% Co-payment
Dialysis (Physician office visit Co-payment may apply)	10% Co-payment
Durable Medical Equipment	10% Co-payment
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.)	10% Co-payment
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	$15 Office Visit Co-payment
Specialist Office Visit	$30 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)	10% 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 Co-payment applies per 30 days.	10% Co-payment
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.)	10% Co-payment per medication

Benefits Available on an Outpatient Basis (Continued)

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.	
Outpatient Injectable Medication	10% Co-payment per medication
Self-Injectable Medication)	10% Co-payment per medication
Laboratory Services (When available through or authorized by your Participating Medical Group. Additional Co-payment for office visits may apply)	$15 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
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	$15 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 Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**)	No charge
Oral Surgery Services	10% Co-payment
Outpatient Habilitative Services and Outpatient Therapy	$15 Office Visit Co-payment
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	$5 Co-payment
Tier 2	$15 Co-payment
Tier 3	$25 Co-payment
Tier 4	10% Co-payment Up to $250 per script
Prescription Drug Deductible (Per member per Calendar Year) Co-payment Maximum of $250 for up to a 30 day supply of an orally administered anticancer medication regardless of a Prescription Drug Deductible and/or Medical Deductible.	None
Outpatient Rehabilitation Services and Outpatient Therapy	$15 Office Visit Co-payment

Benefits Available on an Outpatient Basis (Continued)

Outpatient Surgery at a Network Free-Standing Outpatient Surgery Facility, as authorized by the network medical group.	
Facility fee	10% Co-payment
Physician/surgeon fees	10% Co-payment
Outpatient visit	10% Co-payment
Pediatric Dental Services Diagnostic and Preventive Basic Services Major Services Orthodontics (when Medically Necessary) **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for Pediatric Dental Care Services up to age 19 for a complete 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 Vision Care Services up to age 19 for a complete 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	$15 Office Visit Co-payment
Specialist	$30 Office Visit Co-payment
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 Network 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
Prosthetics and Corrective Appliances	10% Co-payment
Radiation Therapy	
Standard: (Photon beam radiation therapy)	10% Co-payment
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)	10% Co-payment

Benefits Available on an Outpatient Basis (Continued)

Radiology Services Standard: (Additional Co-payment 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 Co-payment will be charged for each part of the body scanned as part of an imaging procedure.	 $30 Co-payment 10% Co-payment
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	10% Co-payment
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 UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	 $15 Office Visit Co-payment 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.	$10 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 NETWORK 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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