UnitedHealthcare®

UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

HMO Schedule of Benefits

20/250A

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

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Copayment Maximum[1,5]	Individual $2,000 Family $6,000
PCP Office Visits	$20 Office Visit Copayment
Specialist Office Visits[2] (Member required to obtain referral to Specialist except for OB/GYN Physician Services and Emergency/Urgently Needed Services)	$20 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
Emergency Services (Copayment waived if admitted)	$100 Copayment
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 area served by your medical group.	 $20 Copayment $50 Copayment

Benefits Available While Hospitalized as an Inpatient

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

Benefits Available While Hospitalized as an Inpatient (Continued)

Mental Health Services including, but not limited to, Residential Treatment Centers (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) **Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.)**	$250 Copayment per admit
Newborn Care 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.	$250 Copayment per admit
Physician Care	No charge
Reconstructive Surgery	$250 Copayment per admit
Rehabilitation Care (Including physical, occupational and speech therapy)	$250 Copayment per admit
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.**	$250 Copayment per admit
Skilled Nursing Facility Care (Up to 100 days per benefit period)	$250 Copayment per admit
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.**	No charge
Termination of Pregnancy (Medical/medication and surgical)	$125 Copayment

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist Office Visit	 $20 Office Visit Copayment $20 Office Visit Copayment
Ambulance	No charge
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 therapy may apply)	No charge
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	$20 Copayment

Benefits Available on an Outpatient Basis (Continued)

Dialysis (Physician office visit Copayment may apply)	$20 Copayment per treatment
Durable Medical Equipment[4]	No charge
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.)	No charge
Family Planning (Non-Preventive Care)[8]	
Vasectomy	$50 Copayment
Depo-Provera Injection – (other than contraception)[8]	
PCP Office Visit	$20 Office Visit Copayment
Specialist Office Visit	$20 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
Hearing Aid - Standard $5,000 benefit maximum per calendar year Limited to one hearing aid (including repair and 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.)	No charge
Hearing Aid – Bone Anchored[6] Repairs and/or replacement 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[2,7]	
PCP Office Visit	$20 Office Visit Copayment
Specialist Office Visit[2]	$20 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	No charge
Hospice Services (Prognosis of life expectancy of one year or less)	No charge
Infertility Services	Not covered
Infusion Therapy[4] (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment.)	No charge
Injectable Drugs[4,8] (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	$50Copayment per medication
Self-Injectable Medication	$50Copayment per medication
Laboratory Services (When available through or authorized by your Participating Medical Group. Additional Copayment for office visits may apply)	No charge
Maternity Care, Tests and Procedures[7]	
PCP Office Visit	No charge
Specialist Office Visit	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	$20 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, 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[4]	No charge
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$20 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	$50 Copayment
Physician Care PCP Office Visit Specialist Office Visit	 $20 Office Visit Copayment $20 Office Visit 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 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

Benefits Available on an Outpatient Basis (Continued)

Prosthetics and Corrective Appliances[4]	No charge
Radiation Therapy[4] Standard: (Photon beam radiation therapy) 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)	 No charge No charge
Radiology Services[4] 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.	 No charge No charge
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**.	
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 the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a complete description of this coverage.**	 No charge 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.	$20 Copayment
Vision Refractions	$20 Office Visit Copayment

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

[1] Annual Copayment Maximum includes Copayments for UnitedHealthcare benefits including behavioral health and prescription drugs. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups.

[2] Copayments for audiologist and podiatrist visits will be the same as for the PCP.

[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] In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate. (This footnote only applies to dollar copayments.)

[5] 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 drug 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 equa 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 a member satisfies the Individual Out-of-Pocket Maximum or until a family satisfies the Individual Out-of-Pocket Maximum.

[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. 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 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
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.myuhc.com

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LargeGroup-NG-SOB CA

CALIFORNIA

UnitedHealthcare®

UnitedHealthcare SignatureValue™ Advantage Offered by UnitedHealthcare of California

HMO Deductible Schedule of Benefits

45-60/30%/3000DED

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

General Features

Calendar Year Deductible[1] On a Family plan, if one individual member meets the Individual deductible amount, his/her deductible is met, and the Family deductible must be met by one or more of the family members.	Individual $3,000 Family $6,000
Maximum Benefits	Unlimited
Annual Out-of-Pocket Maximum[2] On a Family plan, if one individual member meets the Individual out of pocket amount, his/her out of pocket is met and the Family out of pocket must be met by one or more of the family members.	Individual $6,000 Family $12,000
PCP Office Visits	$45 Office Visit Copayment
Specialist Office Visits[3] (Member required to obtain referral to Specialists except for OB/GYN Physician Services and Emergency/Urgently Needed Services)	$60 Office Visit Copayment
Hospital Benefits	30% Copayment after Deductible
Emergency Services (Copayment waived if admitted)	$150 Copayment
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 area served by your medical group.	 $45 Copayment $75 Copayment

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	30% 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)	30% Copayment after Deductible
Hospital Benefits	30% Copayment after Deductible
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	30% Copayment after Deductible
Maternity Care[7]	30% 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 complete description of this coverage.**	30% 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.)	30% Copayment after Deductible
Physician Care	30% Copayment after Deductible
Reconstructive Surgery	30% Copayment after Deductible
Rehabilitation Care (Including physical, occupational and speech therapy)	30% 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 complete description of this coverage.**	30% Copayment after Deductible
Skilled Nursing Facility Care (Up to 100 days per benefit period)	30% 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 complete description of this coverage.**	30% Copayment after Deductible
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 Specialist Office Visit[3]	 $45 Office Visit Copayment $60 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)	$100 Copayment
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.)	$60 Copayment per item
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	$50 Copayment

Benefits Available on an Outpatient Basis (Continued)

Dialysis (Physician office visit Copayment may apply)	$60 Copayment per treatment
Durable Medical Equipment[5]	$70 Copayment 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 under the age of 19.)	30% Copayment
Family Planning (Non-Preventive Care)[8]	
Vasectomy	30% Copayment
Depo-Provera Injection – (other than contraception)[8]	
PCP Office Visit	$45 Office Visit Copayment
Specialist Office Visit[3]	$60 Office Visit Copayment
Depo-Provera Medication – (other than contraception)[8] (Limited to one Depo-Provera injection every 90 days.)	30% Copayment
Termination of Pregnancy (Medical/medication and surgical)	$125 Copayment
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.)	$70 Copayment
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	$45 Office Visit Copayment
Specialist Office Visit[3]	$60 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	$45 Copayment per visit
Hospice Services (Prognosis of life expectancy of one year or less)	30% Copayment
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)	$25 Copayment
Maternity Care, Tests and Procedures[7]	
PCP Office Visit	$45 Office Visit Copayment
Specialist Office Visit	$45 Office Visit Copayment

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	$40 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, 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
Oral Surgery Services[5]	30% Copayment after Deductible
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$45 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	30% Copayment after Deductible
Physician Care PCP Office Visit Specialist Office Visit[3]	 $45 Office Visit Copayment $60 Office Visit 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 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

Benefits Available on an Outpatient Basis (Continued)

Prosthetics and Corrective Appliances[5]	$60 Copayment per item
Radiation Therapy[5] Standard: (Photon beam radiation therapy) 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.)	 No charge $50 Copayment
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.	 No charge $100 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.**	
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 the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for complete a description of this coverage.**	 $40 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
Vision Refractions	$45 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.

[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 drug 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 a member satisfies the Individual Out-of-Pocket Maximum or until a family satisfies the Individual 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 negotiated rate is less than your copayment, you will pay only the negotiated 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. 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 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.

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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
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.myuhc.com

CALIFORNIA

UnitedHealthcare

Mental Health and Substance-Related and Addictive Disorder Services, Provided by U.S. Behavioral Health Plan, California

Schedule of Benefits

Pre-Authorization is required for certain Mental Health Services and Substance-Related and Addictive Disorder Services. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through U.S Behavioral Health Plan, California (USBHPC) for Inpatient services, Residential Treatment services, Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, Outpatient Treatment extended beyond 45 minutes, Partial Hospitalization/ Day Treatment, Behavioral Health Treatment for PDD/ Autism including Applied Behavior Analysis (ABA) and other evidence-based behavioral intervention programs, Medical Detoxification, Methadone Maintenance Treatment; and Psychological Testing, except in the event of an Emergency. USBHPC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

Mental Health Services

Inpatient and Residential Treatment Medically Necessary Mental Health services provided at an Inpatient Treatment Center	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]
Outpatient Treatment (includes individual/ group counseling/ monitoring drug therapy) Outpatient Treatment for Mental Health Services (including SMI and SED conditions) includes Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, Outpatient Electro-Convulsive Therapy (ECT), Outpatient Treatment extended beyond 45 minutes, psychological and neuropsychological testing , applied behavior analysis (ABA) and other evidence-based behavioral intervention programs	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

Substance-Related and Addictive Disorder Services

Inpatient and Residential Treatment Medically Necessary treatment of Substance-Related and Addictive Disorders, Including Medical Detoxification, provided at a Participating Facility	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]

Substance-Related and Addictive Disorder Services (Continued)

Outpatient Treatment Outpatient Treatment for Substance-Related and Addictive Disorder Services includes outpatient evaluation and treatment for chemical dependency: • individual and group Substance-Related and Addictive Disorder counseling; • medical detoxification • methadone maintenance treatment; and • outpatient treatment extended beyond 45 minutes.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

Severe Mental Illness Benefit and Serious Emotional Disturbances of a Child[3]

Inpatient and Residential Treatment Unlimited days	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information[1]
Outpatient Treatment Outpatient Treatment for Mental Health Services (including SMI and SED conditions) includes Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, Outpatient Electro-Convulsive Therapy (ECT), Outpatient Treatment extended beyond 45 minutes, psychological and neuropsychological testing, applied behavior analysis (ABA) and other evidence-based behavioral intervention programs	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Partial Hospitalization/Day Treatment or Intensive Outpatient Treatment.	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information
Emergency and Urgently Needed Services[2]	Please refer to your UnitedHealthcare of California Medical Schedule of Benefits for Copay information

[1] Each Hospital Admission may require an adcitional Copayment. Please refer to your UnitedHealthcare of California Medical Plan *Schedule of Benefits.*

[2] Emergency and Urgently Needed Services are Medically Necessary behavioral health services required outside the Service Area to prevent serious deterioration of a Member's health resulting from an unforeseen illness or injury manifesting itself by acute symptoms of sufficient servility, including severe pain, and may result in immediate harm to self or others; placing one's health in serious jeopardy; serious impairment of one's functioning; or serious dysfunction of any bodily organ or part, therefore such treatment cannot be delayed until the Member returns to the Service Area. Please refer to the Supplement to the Combined Evidence of Coverage and Disclosure Form for detailed information on this benefit.

[3] Severe Mental Illness (SMI) diagnoses incluce: Anorexia Nervosa; Bipolar Disorder; Bulimia Nervosa; Major Depressive Disorders; Obsessive-Compulsive Disorder; Panic Disorder; Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism; Schizoaffective Disorder; Schizophrenia. Serious Emotional Disturbance (SED) of a Child Under Age 18 includes a condition identified as a Mental Disorder in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), other than a primary substance-related and addictive disorder or developmental disorder that result in behavior inappropriate to the child's age according to expected developmental norms if the child also meets at least one of the following three criteria:

- As a result of the Mental Disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either:
  (i) the child is at risk of removal from home or has already been removed from the home; or
  (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
- The child displays psychotic features or risk of suicide or violence due to a Mental Disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

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HMO Pharmacy Schedule of Benefits

Summary of Benefits	Generic Formulary	Brand-name Formulary	Non-Formulary
Retail Pharmacy Copayment (per Prescription Unit or up to 30 days)	$10	$20	$35
Mail Service Pharmacy Copayment (three Prescription Units or up to a 90-day supply)	$20	$40	$70

This Schedule of Benefits provides specific details about your prescription drug benefit, as well as the exclusions and limitations. Together, this document and the Supplement to the Combined Evidence of Coverage and Disclosure Form as well as the medical Combined Evidence of Coverage and Disclosure Form determine the exact terms and conditions of your prescription drug coverage.

What do I pay when I fill a prescription?

You will pay only a Copayment when filling a prescription at a UnitedHealthcare Participating Pharmacy. You will pay a Copayment every time a prescription is filled. Your Copayments are as shown in the grid above.

There are selected brand-name medications where you will pay a generic Copayment of just $10. A copy of the Selected Brands List is available upon request from UnitedHealthcare's Customer Service department and may be found on UnitedHealthcare's Web site at **www.myuhc.com**.

Preauthorization

Selected generic Formulary, brand-name Formulary and non-Formulary medications require a Member to go through a Preauthorization process using criteria based upon Food and Drug Administration (FDA)-approved indications or medical findings, and the current availability of the medication. UnitedHealthcare reviews requests for these selected medications to ensure that they are Medically Necessary, being prescribed according to treatment guidelines consistent with standard professional practice and are not otherwise excluded from coverage.

Because UnitedHealthcare offers a comprehensive Formulary, selected non-Formulary medications will not be covered until one or more Formulary alternatives, or non-Formulary preferred drugs have been tried. UnitedHealthcare understands that situations arise when it may be Medically Necessary for you to receive a certain medication without trying an alternative drug first. In these instances, your Participating Physicians will need to provide evidence to UnitedHealthcare in the form of documents, lab results, records or clinical trials that establish the use of the requested medications as Medically Necessary. Participating Physicians may call or fax Preauthorization requests to UnitedHealthcare. Applicable Copayments will be charged for prescriptions that require Preauthorization if approved.

For a list of the selected medications that require UnitedHealthcare's Preauthorization, please contact UnitedHealthcare's Customer Service department.

Medication Covered by Your Benefit

When prescribed by your Participating Physician as Medically Necessary and filled at a Participating Pharmacy, subject to all the other terms and conditions of this outpatient prescription drug benefit, the following medications are covered:

- **Disposable all-in-one prefilled insulin pens**, insulin cartridges and needles for nondisposable pen devices are covered when Medically Necessary, in accordance with UnitedHealthcare's Preauthorization process.
- **Federal Legend Drugs**: Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs:** Comparable generic drugs may be substituted for brand-name drugs unless they are on UnitedHealthcare's Selected Brands List. A copy of the Selected Brands List is available upon request from UnitedHealthcare's Customer Service department or may be found on UnitedHealthcare's Web site at **www.myuhc.com**.
- **Miscellaneous Prescription Drug Coverage**: For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, urine test strips and anaphylaxis prevention kits (including, but not limited to, EpiPen®, Ana-Kits® and Ana-Guard®). See the

medical Combined Evidence of Coverage and Disclosure Form for coverage of other injectable medications in Section Five under "Your Medical Benefits."

- **Oral Contraceptives:** Federal Legend oral contraceptives, prescription diaphragms and oral medications for emergency contraception.
- **State Restricted Drugs**: Any medicinal substance that may be dispensed by prescription only, according to state law.

Exclusions and Limitations

While the prescription drug benefit covers most medications, there are some that are not covered or limited. These drugs are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form titled "Your Medical Benefits" for more information about medications covered by your medical benefit.

- **Administered Drugs**: Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff are not covered. Injectable drugs are covered under your medical benefit when administered during a Physician's office visit or self-administered pursuant to training by an appropriate health care professional. Refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form titled "Your Medical Benefits" for more information about medications covered under your medical benefit.
- **Compounded Medication**: Any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. Compounded medications are not covered unless Preauthorized as Medically Necessary by UnitedHealthcare.
- **Diagnostic Drugs**: Drugs used for diagnostic purposes are not covered. Refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form for information about medications covered for diagnostic tests, services and treatment.
- **Dietary or nutritional** products and food supplements, whether prescription or nonprescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine, are not covered. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Participating Physician provided that the diet is Medically Necessary. For additional information, refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form.
- **Drugs prescribed by a dentist** or drugs when prescribed for dental treatment are not covered.
- **Drugs when prescribed to shorten the duration of a common cold** are not covered.
- **Enhancement medications** when prescribed for the following nonmedical conditions are not covered: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Penlac®, Retin-A®, Renova®, Vaniqa®, Propecia®, Lustra®, Xenical® or Meridia®. This exclusion does not exclude coverage for drugs when Preauthorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including, but not limited to, Alzheimer's dementia.
- **Infertility:** All forms of prescription medication when prescribed for the treatment of infertility are not covered. If your Employer has purchased coverage for infertility treatment, prescription medications for the treatment of infertility may be covered under that benefit. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form titled "Your Medical Benefits" for additional information.
- **Injectable Medications**: Except as described under the section "Medications Covered by Your Benefit," injectable medications, including, but not limited to, self-injectables, infusion therapy, allergy serum, immunization agents and blood products, are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical Combined Evidence of Coverage and Disclosure Form. Outpatient injectable medications administered in the Physician's office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to UnitedHealthcare's Preauthorization requirements. For additional information, refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form under "Your Medical Benefits."
- **Inpatient Medications**: Medications administered to a Member while an inpatient in a Hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this Pharmacy Schedule of Benefits. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form titled "Your Medical Benefits" for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are

obtained from a Participating Pharmacy in accordance with all the terms and conditions of coverage set forth in this Schedule of Benefits and in the Pharmacy Supplement to the Combined Evidence of Coverage and Disclosure Form. When a Member is receiving Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Participating Physician at a Participating Pharmacy and pay the applicable Copayment on behalf of the Member.

- **Investigational or Experimental Drugs:** Medication prescribed for experimental or investigational therapies are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical Combined Evidence of Coverage and Disclosure Form in Section Five, "Your Medical Benefits" and Section Eight, "Overseeing Your Health Care" for appeal rights.
- **Medications dispensed by a non-Participating Pharmacy** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **Medications prescribed by non-Participating Physicians** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **New medications that have not been reviewed for safety, efficacy and cost-effectiveness and approved** by UnitedHealthcare are not covered unless Preauthorized by UnitedHealthcare as Medically Necessary.
- **Non-Covered Medical Condition**: Prescription medications for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary medications directly related to non-Covered Services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.
- **Off-Label Drug Use**. Off Label Drug Use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. UnitedHealthcare excludes coverage for Off Label Drug Use, including off label self-injectable drugs, except as described in the medical Combined Evidence of Coverage and Disclosure Form and any applicable Attachments. If a drug is prescribed for Off-Label Drug Use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a participating licensed health care professional. (3) The drug is Medically Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: (a) *The American Hospital Formulary Service Drug Information*, (b) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapy regimen: (i) *The Elsevier Gold Standard's Clinical Pharmacology*; (ii) *The National Comprehensive Cancer Network Drug and Biologics Compendium*; (iii) *The Thompson Micromedex DRUGDEX*, or (c) Two articles from major peer reviewed medical journals that present data supporting the proposed Off-Label Drug Use or uses as generally safe and effective. Nothing in this section shall prohibit UnitedHealthcare from use of a Formulary, Copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as investigational or experimental will allow the Member to use the Independent Medical Review System as defined in the medical *Combined Evidence of Coverage and Disclosure Form*.
- **Over-the-Counter Drugs**: Medications (except insulin) available without a prescription (over-the-counter) or for which there is a nonprescription chemical and dosage equivalent available, even if ordered by a Physician, are not covered. All nonprescription (over-the-counter) contraceptive jellies, ointments, foams or devices are not covered.
- **Prior to Effective Date**: Drugs or medicines purchased and received prior to the Member's effective Date or subsequent to the Member's termination are not covered.
- **Replacement** of lost, stolen or destroyed medications are not covered.
- **Saline and irrigation solutions** are not covered. Saline and irrigation solutions are covered when Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or Durable Medical Equipment benefit. Refer to your medical Combined Evidence of Coverage and Disclosure Form Section Five for additional information.
- **Sexual Dysfunction Medication:** All forms of medications when prescribed for the treatment of sexual dysfunction, which includes, but is not limited to, erectile dysfunction, impotence, anorgasmy or hyporgasmy, are not covered. An example of such medications includes Viagra.
- **Smoking cessation products,** including, but not limited to, nicotine gum, nicotine patches and nicotine nasal spray, are not covered. However, smoking cessation products are covered when the Member is enrolled in a smoking cessation program approved by UnitedHealthcare. For information on UnitedHealthcare's smoking cessation program, refer to the medical Combined Evidence of Coverage and Disclosure Form in Section Five, "Your Medical

Benefits, in the section titled "Outpatient Benefits", under "Health Education Services" or contact Customer Service or visit our Web site at **www.myuhc.com**.

- **Therapeutic devices or appliances,** including, but not limited to, support garments and other nonmedical substances, insulin pumps and related supplies (these services are provided as Durable Medical Equipment) and hypodermic needles and syringes not related to diabetic needs or cartridges are not covered. Birth control devices and supplies or preparations that do not require a Participating Physician's prescription by law are also not covered, even if prescribed by a Participating Physician. For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical Combined Evidence of Coverage and Disclosure Form in Section Five, titled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections titled "Diabetic Self Management", "Durable Medical Equipment," or "Home Health Care and Prosthetics and Corrective Appliances."
- **Workers' Compensation**: Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about workers' compensation can be found in the medical Combined Evidence of Coverage and Disclosure Form in Section Six under "Payment Responsibility."

UnitedHealthcare reserves the right to expand the Preauthorization requirement for any drug product.

Questions? Call the HMO Customer Service department at 1-800-624-8822 or 711 (TTY).

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