

# SignatureValue<sup>™</sup> HMO Offered by UnitedHealthcare of California

CS VEBA Alliance HMO E1 20-30/500A

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 Out-of-Pocket Limit	Individual \$3,000
Annual Out-of-Pocket Limit includes Co-payments for UnitedHealthcare benefits including behavioral health and prescription drug. It does not include standalone, separate and independent Dental, Vision and Chiropractic benefit plans offered to groups. Co-payments for certain types of Covered Health Care Services do not apply toward the Out-of-Pocket Limit and will require a Co-payment even after the Out-of-Pocket Limit has been met. The Annual Out-of- Pocket Limit includes Co-payments 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 Co- payments for the Calendar Year equal to the Individual Out-of-Pocket Limit, no further Co-payments will be due for Covered Health Care Services for the remainder of that Calendar Year. The remaining family members will continue to pay the applicable Co-payment until a member satisfies the Individual Out-of-Pocket Limit or until a family	Family \$6,000
satisfies the Family Out-of-Pocket Limit. PCP Office Visits	\$20 Office Visit Co-payment
Specialist Office Visits (Member required to obtain referral to Specialists except for OB/GYN Physician Services and Emergency/Urgently Needed Services) Co-payments for audiologist and podiatrist visits will be the same as for the PCP.	\$30 Office Visit Co-payment
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)	\$500 Co-payment per admit
Emergency Services (Copayment waived if admitted)	\$150 Co-payment
Urgently Needed Services Urgent care services – services provided <b>within</b> the area	\$20 Co-payment
served by your medical group Urgent care services – services provided <b>outside</b> of the 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.	\$75 Co-payment

## Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	\$500 Co-payment per admit
Clinical Trials	Paid at negotiated rate
Clinical Trial services require prior authorization by UnitedHealthcare. If you	Balance (if any) is the responsibility
participate in a Cancer Clinical Trial provided by an Out-of-Network Provider that	of the Member
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 Participating Providers, in addition to any	
applicable Co-payments, coinsurance or deductibles.	
Hospice Services	\$500 Co-payment per admit
(Prognosis of life expectancy of one year or less)	\$500 Co-payment per admit
	¢E00 Co poverent por admit
Hospital Benefits	\$500 Co-payment per admit
(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)	
Mastectomy/Breast Reconstruction	\$500 Co-payment per admit
(After mastectomy and complications from mastectomy)	
Maternity Care	\$500 Co-payment per admit
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 Co-payment for the office visit and other additional charges for services	
rendered. Please call the Customer Service number on your ID card.	
Mental Health Services including, but not limited to, Residential Treatment	\$500 Co-payment per admit
Centers	
Please refer to your UnitedHealthcare of California Combined Evidence	
of Coverage and Disclosure Form for a complete description of this	
<b>coverage.)</b> (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)	
Newborn Care	\$500 Co payment per admit
	\$500 Co-payment per admit
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.	
Physician Care	No charge
Reconstructive Surgery	\$500 Co-payment per admit
Rehabilitation Care	\$500 Co-payment per admit
(Including physical, occupational and speech therapy)	
Severe Mental Illness Benefit and	\$500 Co-payment per admit
Serious Emotional Disturbances of a Child	4000 00-payment per admit
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	No charge
(Up to 100 days per benefit period)	
Substance Related and Addictive Disorder including, but not	No charge
limited to, Inpatient Medical Detoxification and Residential	5
Treatment Centers	
Please refer to your UnitedHealthcare of California	
Combined Evidence of Coverage and Disclosure Form for a	
complete description of this coverage.	
Termination of Pregnancy	\$50 Co-payment
(Medical/medication and surgical)	φ50 CO-payment

## Benefits Available on an Outpatient Basis

\$20 Office Visit Co-payment
\$30 Office Visit Co-payment
No charge
Paid at negotiated rate
Balance (if any) is the responsibility
of the Member
\$30 Co-payment per item
450 CO-payment per item
\$30 Co-payment
/)
\$20 Co-payment per treatment
No charge
No charge
)
will be the applicable Physician office
utpatient Surgery or Inpatient Surgery
Co-payment
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\$50 Co-payment <b>T</b> No charge el 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
\$50 Co-payment T No charge el Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those
\$50 Co-payment <b>T</b> No charge el 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

Benefits Available on an Outpatient Basis (Continued)	
Hearing Exam	No charge
PCP Office Visit	Ū.
Specialist Office Visit	
Co-payments for audiologist and podiatrist visits will be the same as for the PCP.	
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 Co-payment for the office visit and	
other additional charges for services rendered. Please call the Customer Service number	
on your ID card. Home Health Care Visits	No oberro
Home Health Care Visits	No charge
Hospice Services	No charge
(Prognosis of life expectancy of one year or less)	
Infertility Services	Not covered
Infusion Therapy	No charge
(Infusion Therapy is a separate Co-payment in addition to an office visit Co-payment.) In	
instances where the negotiated rate is less than your Co-payment, you will pay only the	
negotiated rate Injectable Drugs	No charge
Outpatient Injectable Medication	No onarge
Self-Injectable Medication	
(Co-payment/Coinsurance not applicable to injectable immunizations, birth control, Infertility	
and insulin. If injectable drugs are administered in a physician's office, office visit Co-	
payment/Coinsurance 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 <u>NOT</u> defined as Covered Health Care Services under the	
Preventive Care Services and Family Planning benefit as specified in the Combined	
Evidence of Coverage and Disclosure Form.	
Laboratory Services	No charge
(When available through or authorized by your Participating Medical Group. Additional	
Copayment for office visits may apply.)	
Maternity Care, Tests and Procedures	
PCP Office Visit	No charge
Specialist Office Visit	No charge
Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services T	ask
Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the	
Health Resources and Services Administration as preventive care services will be covered a Paid in Full. There may be a separate Co-payment for the office visit and other additional	15
charges for services rendered. Please call the Customer Service number on your ID card.	
Mental Health Services (including Severe Mental Illness and Serious Emotional	
Disturbances of a Child)	
Outpatient Office Visits include:	\$20 Office Visit Co-payment
Diagnostic evaluations, assessment, treatment planning, treatment and/or procedures,	
individual/ group counseling, individual/ group evaluations and treatment, referral	
services, and medication management	
All Other Outpatient Treatment include:	No charge
Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment, crisis	i i e energe
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.)	
Oral Surgery Services	\$30 Co-payment
In instances where the negotiated rate is less than your Co-	
payment, you will pay only the negotiated rate.	

### Benefits Available on an Outpatient Basis (Continued)

Benefits Available on an Outpatient Basis (Continued)	
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or	\$20 Office Visit Co-payment
Outpatient Facility (Including physical, occupational and speech therapy)	
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	\$250 Co-payment per admit
Physician Care	
PCP Office Visit	\$20 Office Visit Co-payment
Specialist Office Visit	\$30 Office Visit Co-payment
Preventive Care Services	No charge
(Services as recommended by the American Academy of Pediatrics (AAP) including the	No charge
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 Health Care 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. Preventive tests/screenings/counseling as recommended by the U.S.	
Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric	
preventive services rask roles, AAP (Bright rutiles Recommendations for pediatic preventive health care) and the Health Resources and Services Administration as	
preventive real real of and the real reasonables and dervices raministration as preventive care services will be covered as Paid in Full. There may be a separate Co-	
payment for the office visit and other additional charges for services rendered. Please	
call the Customer Service number on your ID card.	
Prosthetics and Corrective Appliances	No charge
Radiation Therapy	No oborgo
Standard:	No charge
(Photon beam radiation therapy)	No oborgo
Complex:	No charge
(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)	
In instances where the negotiated rate is less than your Co-payment, you will pay only the	
negotiated rate.	
Radiology Services	
Standard:	No charge
(Additional Co-payment for office visits may apply)	
Specialized Scanning and Imaging Procedures:	\$200 Co-payment
(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. In instances where the negotiated rate is less than your Co-payment,	
you will pay only the negotiated rate.	
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.	

### Benefits Available on an Outpatient Basis (Continued)

Substance Related and Addictive Disorder	
Outpatient Office Visits include, but are not limited to:	No charge
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:	No charge
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.	
Virtual Visits	\$20 Co-payment
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.	
Vision Refractions	No charge
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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 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.